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U.S. HOUSE OF REPRESENTATIVES

MEDICARE AND HEALTH CARE CHARTBOOK

MAY 17, 1999

Prepared for the use of Members of the Committee on Ways and Means. This document has not been officially approved by the Committee and may not reflect the views of its Members

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U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS
BILL ARCHER, TEXAS, *Chairman*

A.L. SINGLETON, *Chief of Staff*

This document was prepared by the majority staff of the Committee on Ways and Means and is issued under the authority of Chairman Bill Archer. This document has not been reviewed or officially approved by the Members of the Committee.

Introduction

In 1997, Americans spent nearly $1.1 trillion on health care and health-related services and supplies. This amount represented 13.5% of the economy as measured by the gross domestic product (GDP) of the United States, up from only 5% in 1960. The Congressional Budget Office (CBO) estimates that by the year 2008 health expenditures will be slightly more than $2 trillion, which, in that year, will represent 15.5% of the economy.

Although spending on health care as a percent of the economy is expected to rise in the future, since 1995 it has remained relatively constant at between 13.7% and 13.5% of GDP. This low rate of growth reflects a variety of factors, including a decline in fee-for-service health insurance and an increase in coverage of managed care plans as well as generally low inflation and a strong U.S. economy.

Most Americans have group health insurance through their own or a family member's employment (63% of the population). However, 16% of the population was without insurance coverage in 1997 (43 million individuals), including 11.6 million children under age 19. Medicare and Medicaid covered 22% of the population, and 10% had private, nongroup coverage.

In 1997 the CBO estimated that Medicare's Part A trust fund (which covers hospital and related services) would become insolvent in about the year 2001. Recent CBO estimates indicate that the Medicare provisions in the Balance Budget Act of 1997 (BBA) will delay depletion of the trust fund until at least 2010. Nevertheless, the program will incur large spending increases as the baby boom generation reaches retirement age in 2011.

In order to reduce cost growth under the Medicare program, Congress in 1982 sought alternatives to the open-ended spending design of the traditional fee-for-service Medicare program by authorizing private health plans, such as HMOs, to provide health care to Medicare beneficiaries for a fixed annual payment per beneficiary known as a "capitated payment." In BBA, Congress enacted the Medicare+Choice program which modified the 1982 law to create new capitated plan options and change the formula determining the government's payment per beneficiary. At the start of 1999, about 300 Medicare+Choice plans participated in Medicare and enrolled about 16% of Medicare beneficiaries.

This Chartbook provides data and information on national health care spending (Section 1); the health insurance coverage of various segments of the population (Section 2); the traditional Medicare program (Section 3); and Medicare Health Maintenance Organizations (Section 4). It was prepared by a team of Congressional Research Service analysts including: Rich Rimkunas, Madeleine Smith, Dadi Einarsson, Jennifer O'Sullivan, Sibyl Tilson, and Richard Price. Carolyn Merck served as the project coordinator. Phillip Brogsdale produced the report in a professional and timely manner.

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Medicare and Health Care Chartbook

May 1999

Section 1.
What We Spend on Health Care

U.S. health care spending patterns in the mid–1990s reflect some important delivery and financing changes. This first section of the chartbook provides selected information on health spending in the United States that will help place Medicare spending within a broader context. It provides data on overall health expenditure trends and expenditure trends for three major health services: hospitals, physicians, and nursing homes. The figures convey information on the overall size of health expenditures in the United States, the public role in paying for those costs, and shifting patterns among the sources of payment for them.

The national health expenditure data provide summary spending trends for health services and supplies and other related health expenditures. The expenditure trends shown here portray total spending on health services, supplies and other activities. Changes in the price of services, supplies or insurance are incorporated into these summary trends, along with any changes in the use of health services and supplies.

This section answers some basic questions about health spending in the United States:

- How much do we spend on health services and supplies?
- Who pays for this spending?
- How has health spending changed over the last 37 years?
- How do sources of payment vary by type of service?
- How have we utilized these services?

Most figures presented in this section rely on data developed by the Office of National Health Statistics in the Office of the Actuary at the Health Care Financing Administration (HCFA).

Figure 1.1.
National Health Expenditures, 1960–1997

National health expenditures include spending on health care services and supplies, health research and construction, administration and the net cost of private health insurance. The size of this aggregate spending amount is influenced by such factors as the size of the U.S. population, the population's use of medical services and supplies, and reimbursement for those services and supplies.

In 1960, national health care spending accounted for 5.1% of the Gross Domestic Product (GDP), the commonly used indicator of the size of the overall economy. The enactment of Medicare and Medicaid and the expansion of private health insurance covered services contributed to a health spending trend that, over much of the 37-year period, grew much more quickly than the overall economy.

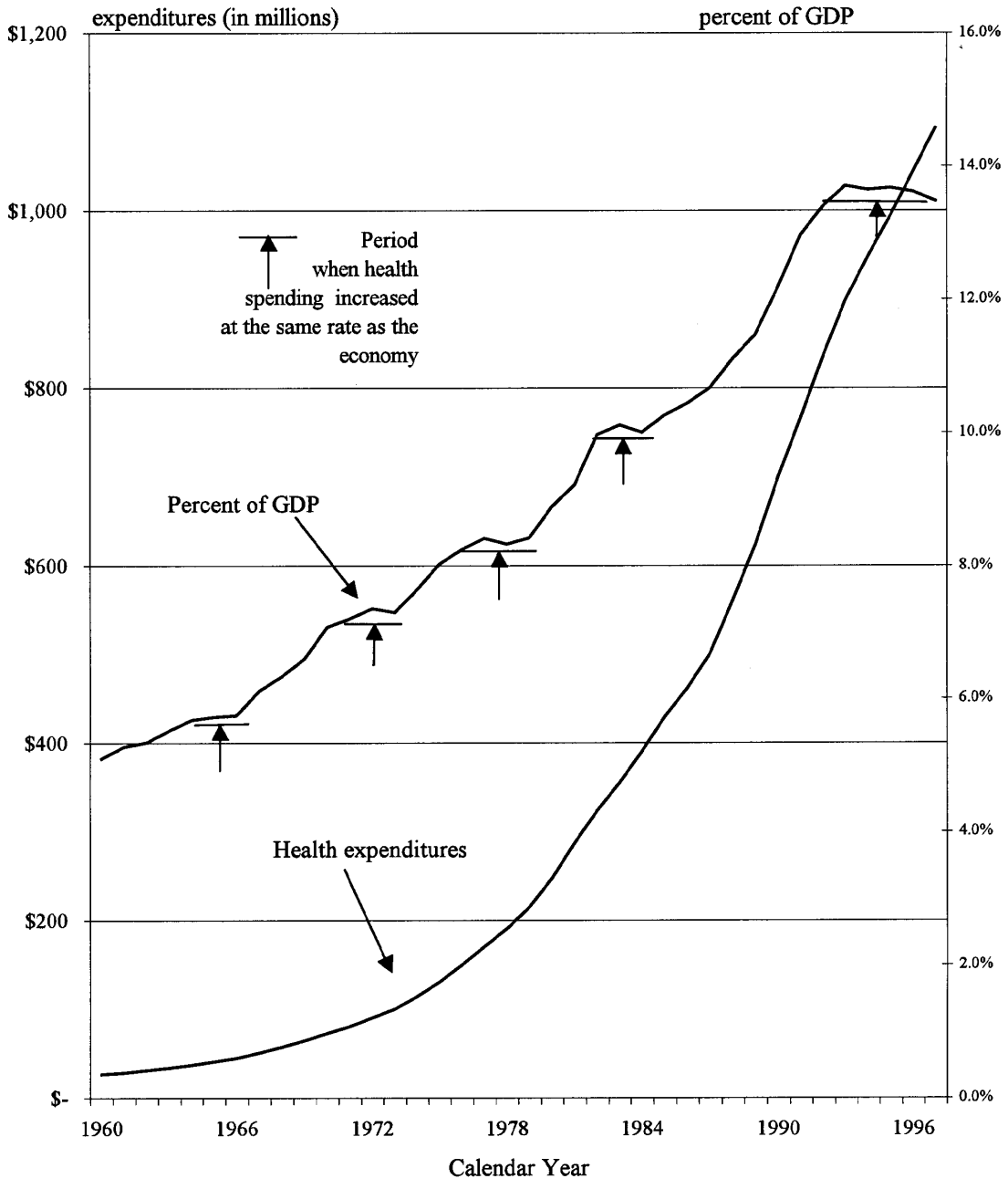
From 1960–1997, four periods are exceptions to the rule that the growth in U.S. health spending outpaced the growth of the overall economy. The 1964–1966 period, the 1977–1979 period, and the 1982–1984 period are times when there was no substantial change in the share of the U.S. economy spent on health. Each of these was characterized by substantial growth in the overall economy. The fourth period, 1992–1997, also shows health spending representing roughly the same share of the economy (between 13.4% and 13.7%). However, unlike these earlier periods, during the nineties health spending grew at an historically lower rate—close to the moderate rate of growth in the overall economy.

TABLE 1.1. National Health Expenditures and Expenditures as a Percent of GDP, 1960–1997

Calendar Year	National Health Expenditures (in billions)	Percent of GDP
1960	$26.9	5.1
1965	41.1	5.7
1970	73.2	7.1
1975	130.7	8.0
1980	247.3	8.9
1985	428.7	10.3
1990	699.4	12.2
1995	993.7	13.7
1996	1042.5	13.6
1997	1092.4	13.5

Note: Table prepared by CRS.

Figure 1.1. National Health Expenditures, 1960 - 1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, National Cost Estimates, HCFA.

Figure 1.2.
Health Spending as a Share of the Economy in Selected Nations, 1960–1997

As depicted in this figure, health care spending in the United States far exceeds that of most other industrialized Nations when measured as a share of the economy. In 1997, the United States spent 13.5% of its economy on health. This can be compared with Germany's 10%, Canada's 9% and Japan and Great Britain's 7%.

Figure 1.2 compares health spending as a share of the economy in selected Nations. Health spending in different countries differs for a variety of reasons, including different types of public and private health insurance plans and benefits; different medical education systems and approaches to treating illnesses; and differing health characteristics of the populations. These and other factors affect the share of a Nation's economy spent on health care.

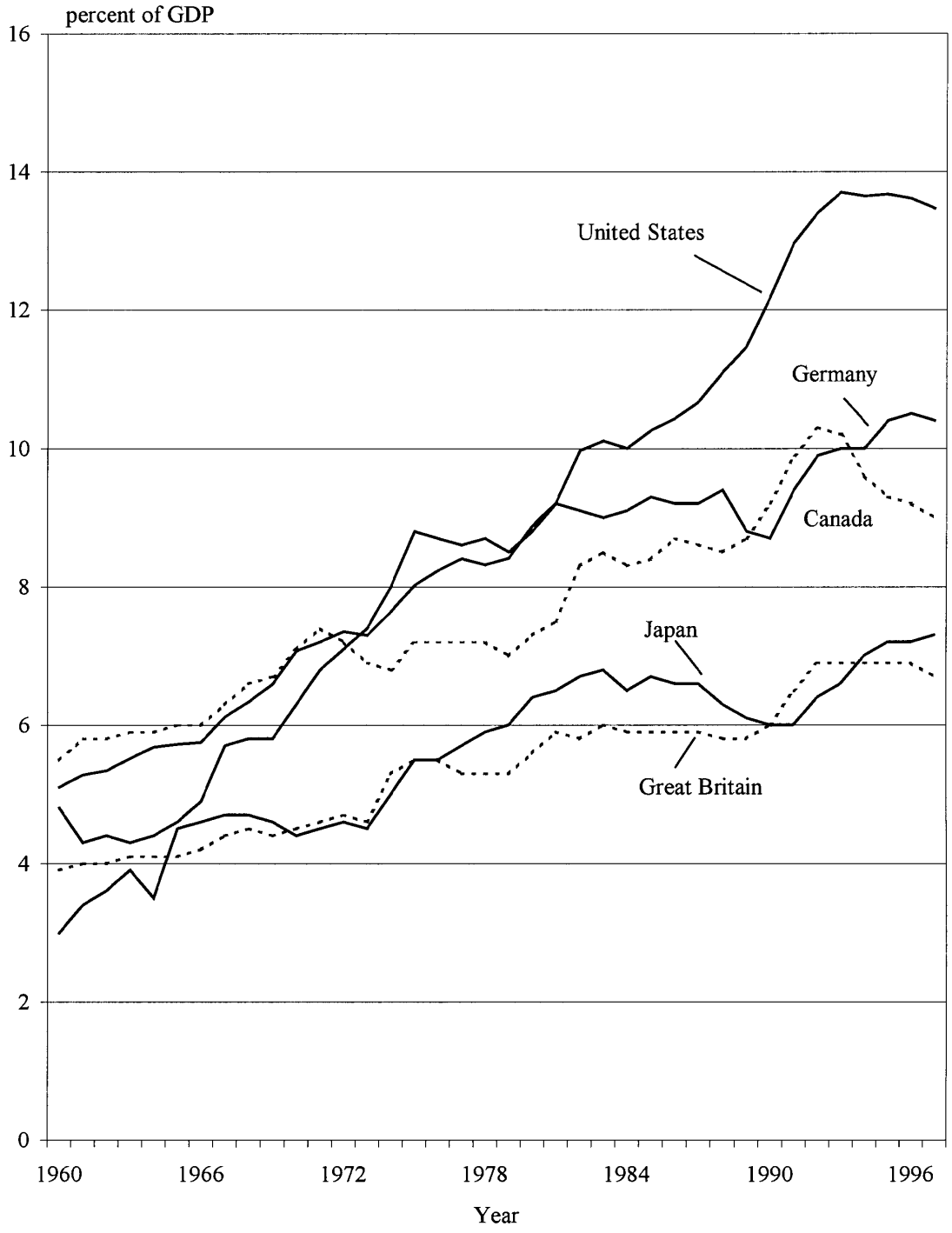
TABLE 1.2. Health Spending as a Share of the Economy in Selected Nations, 1960–1997

(Expenditures as a percent of national GDP)

Calendar Year	United States	Great Britain	Canada	Germany	Japan
1960	5.1	3.9	5.5	4.8	3.0
1965	5.7	4.1	6.0	4.6	4.5
1970	7.1	4.5	7.1	6.3	4.4
1975	8.0	5.5	7.2	8.8	5.5
1980	8.9	5.6	7.3	8.8	6.4
1985	10.3	5.9	8.4	9.3	6.7
1990	12.2	6.0	9.2	8.7	6.0
1995	13.7	6.9	9.3	10.4	7.2
1996	13.6	6.9	9.2	10.5	7.2
1997	13.5	6.7	9.0	10.4	7.3

Note: Table prepared by CRS.

Figure 1.2. Health Spending as a Share of the Economy in Selected Nations, 1960-1997



Source: Figure prepared by CRS based on data from the Organization of Economic Cooperation and Development and HCFA.

Figure 1.3.
Who Pays Our Health Bills, 1997

Figure 1.3 shows health expenditures by payment source. Private spending is the largest payment source for health care in the United States, accounting for 54% of all expenditures. Federal spending (primarily through the Medicare and Medicaid programs) is the largest single contributor, accounting for 34% of all spending.

Private health insurance includes employer-based group insurance plans and individually purchased policies.

Out-of-pocket spending includes payments made by insured individuals for premiums, coinsurance, copayments and deductibles, as well as health services and items not covered by insurance. Out-of-pocket payments also include payments by persons without insurance coverage.

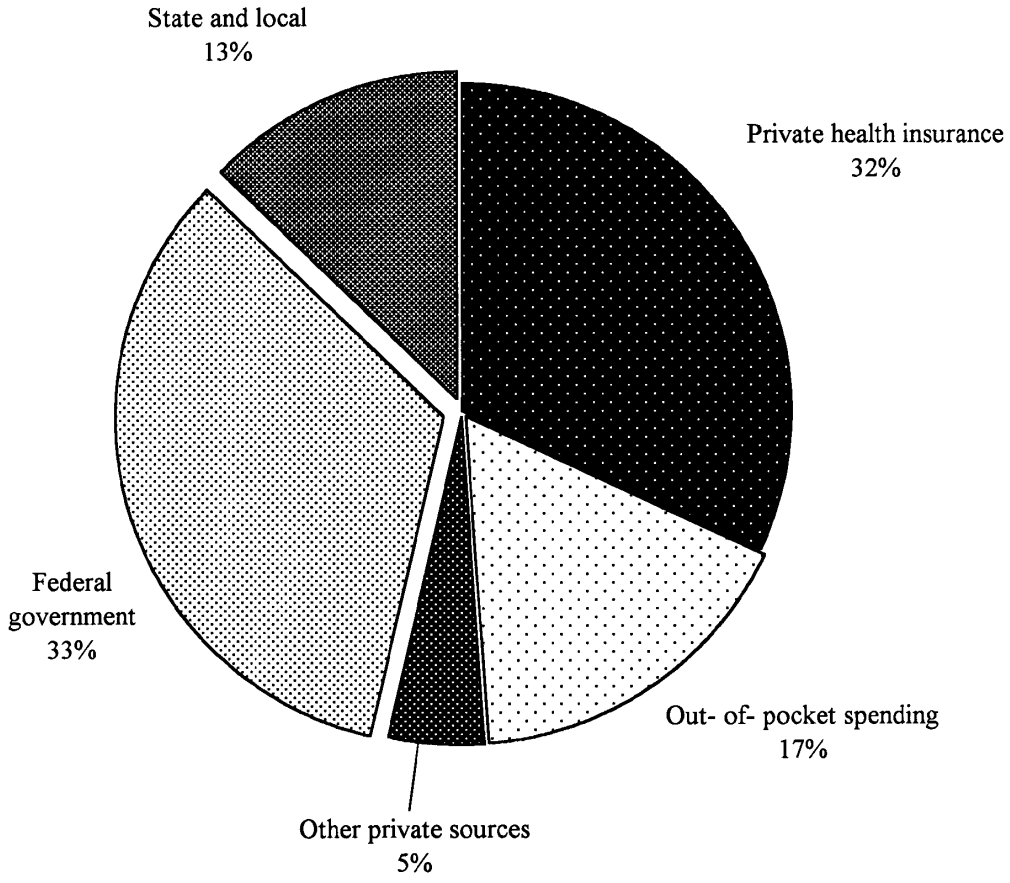
TABLE 1.3. Health Spending by Major Funding Source

Funding Source	Expenditures (in millions)	Percent of Total
Private health insurance	$348,020	31.9
Out-of-pocket spending	187,551	17.2
Other private spending	49,741	4.6
Federal spending	367,050	33.6
State and local spending	140,023	12.8
All private sources	585,312	53.6
All public sources	507,073	46.4
Total	$1,092,385	100.0

Note: Table prepared by CRS.

Figure 1.3. Who Pays Our Health Bills, 1997

Total Expenditures = $1,092 Billion



Source: Chart prepared by CRS based on data from the Office of the Actuary, National Cost Estimates, HCFA.

Figure 1.4.
Health Spending by Payment Source, 1960–1997

Over the last 37 years there has been a substantial shift in the relative role of various payers of health services. This stems from a number of factors including the enactment and expansion of Medicare and Medicaid, changes in reimbursement practices for these federal programs, and changes in private health insurance. Importantly, private health insurance has shifted away from the fee-for-service-based reimbursement system to managed care prepayment and mixed compensation systems.

The first significant shift in payment source depicted in figure 1.4 occurred shortly after 1965 reflecting the enactment of the Medicare and Medicaid programs. In 1964, before their enactment, the federal government contributed about 12% to all health expenditures. By 1970, the federal government's share increased to 24%. Federal spending continued its rise as a percent of all expenditures until 1976 when it represented about 28 cents of each health dollar. Between 1976 and 1990, the share of health spending paid by the federal government hovered around 28%. Since 1990, federal spending on health has grown from this plateau to represent ⅓ of all health spending in 1996.

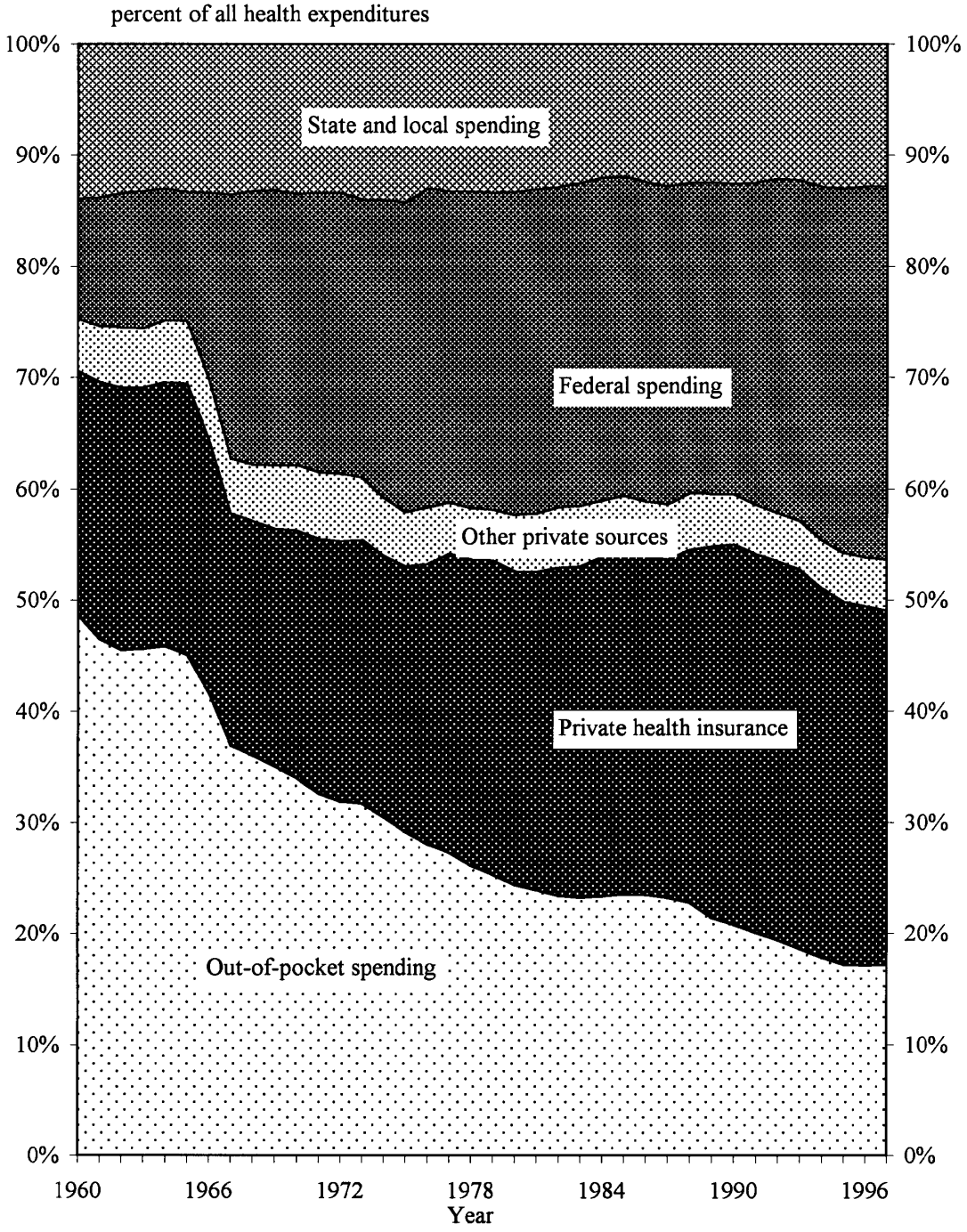
Perhaps the most dramatic trend depicted in the figure is the reduction in the share of health expenditures paid for by individuals out-of-pocket. In 1960, almost half of all health expenditures were paid out-of-pocket. The growth of private health insurance and public health programs results in out-of-pocket spending accounting for about ⅙ of all health spending.

TABLE 1.4. Health Spending by Payment Source, 1960–1997

Calendar Year	Out-of-Pocket Payments	Private Health Insurance	Other Private	Federal Spending	State and Local Spending	Total Expenditures (in millions)
1960	48.7	21.9	4.7	10.9	13.9	$26,850
1965	45.1	24.4	5.6	11.7	13.3	41,145
1970	34.0	22.2	5.9	24.3	13.5	73,243
1975	29.1	23.9	4.8	27.8	14.2	130,727
1980	24.4	28.2	5.0	29.1	13.3	247,273
1985	23.5	31.0	4.9	28.7	11.9	428,720
1990	20.7	34.1	4.5	27.9	12.6	699,361
1995	17.2	32.6	4.4	32.8	13.0	993,725
1996	17.1	32.3	4.4	33.4	12.8	1,042,522
1997	17.2	31.9	4.6	33.6	12.8	1,092,385

Note: Table prepared by CRS.

Figure 1.4. Health Spending by Payment Source, 1960-1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, National Cost Estimates, HCFA.

Figure 1.5.
Health Spending as a Share of Government Expenditures, 1960–1997

Over the last 37 years, the share of government spending going to health has grown substantially. In 1960, health spending represented a minor component of all federal spending (accounting for just over 3% of each federal dollar). The enactment of the Medicare and Medicaid programs in the mid–1960s, and the program expansions contributed to health representing about 12% of federal expenditures by 1980. Since 1980, health spending has grown to 21% of each federal dollar spent.

Spurred on largely as a result of increased Medicaid spending, the share of state and local spending dedicated to health has increased from 12% of state and local expenditures in 1960 to 18.5% in 1997. While the share of state and local budgets dedicated to health has increased, their share of spending has not increased as rapidly as the federal government's share. Caution should be used in interpreting this state and local trend. Individual states and localities may spend substantially more or less of their budgets on health. In addition, state and local balanced budget requirements may have an impact on this trend.

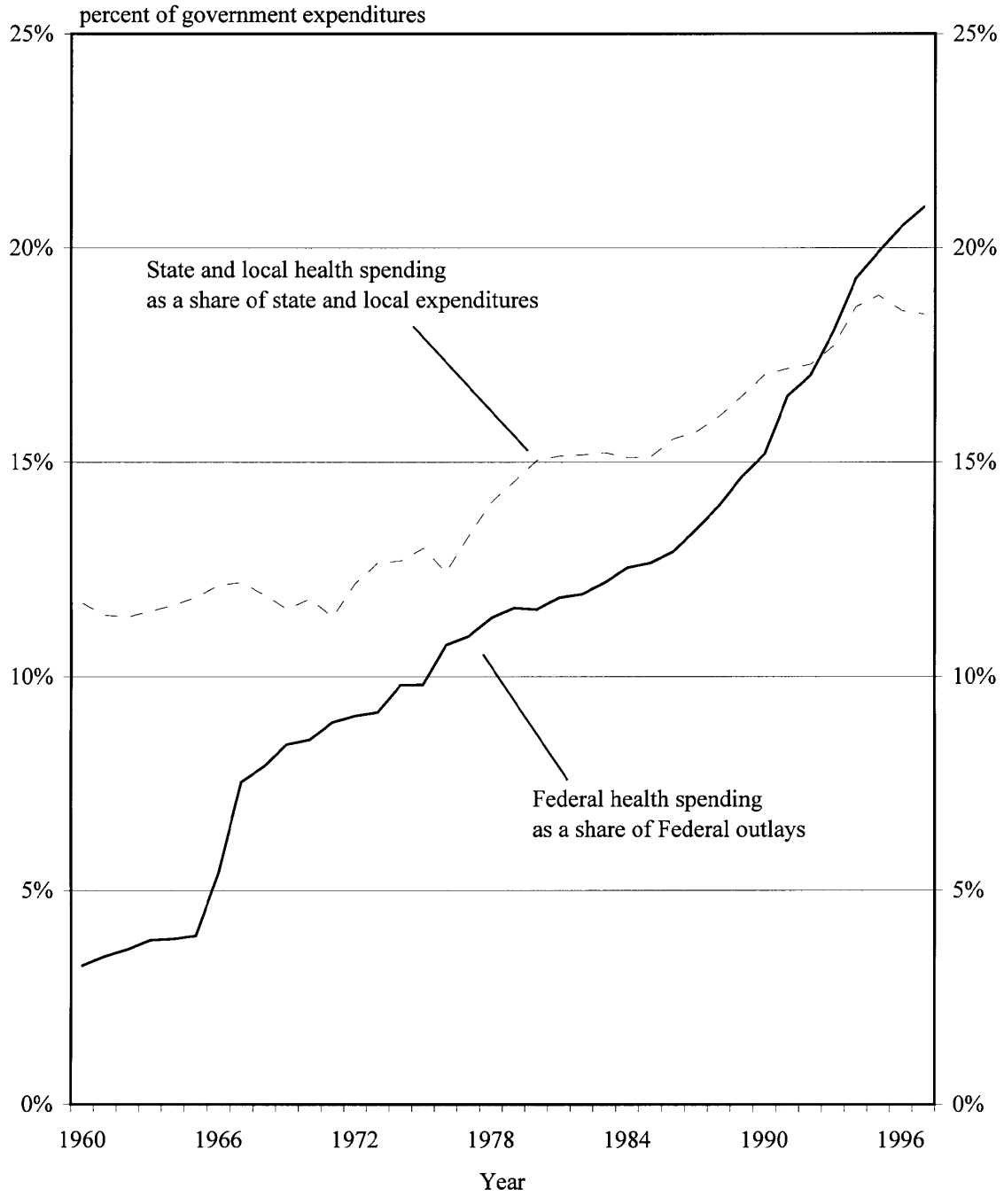
TABLE 1.5. Health Spending as a Share of Government Expenditures, 1960–1997

($ in millions)

Calendar Year	Federal Expenditures	Percent of All Federal Expenditures	State and Local Expenditures	Percent of All State and Local Expenditures
1960	$2,914	3.3	$3,734	11.7
1965	4,820	3.9	5,458	11.8
1970	17,816	8.5	9,890	11.8
1975	36,407	9.8	18,625	13.0
1980	71,958	11.6	32,823	15.0
1985	123,171	12.6	51,032	15.1
1990	195,181	15.2	87,993	17.0
1995	328,705	19.9	129,229	18.9
1996	348,009	20.5	133,373	18.5
1997	367,050	21.0	140,023	18.5

Note: Table prepared by CRS.

Figure 1.5. Health Spending as a Share of Government Expenditures, 1960-1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, Office of National Health Statistics.

Figure 1.6.
Per Capita Health Spending in Selected Nations, 1960–1994

A previous figure (figure 1.2) shows that the United States spends a substantially larger share of its economy on health than other nations. There are a number of factors that are likely to account for this, including the size and age distribution of a nation's population.

Figure 1.6 adjusts cross-national health spending patterns by taking into account the relative size of each nation's population. The table and figure convert each nation's health expenditures into U.S. dollars using a measure of purchasing power parity (PPP). The PPP is an index used to convert national currency units to a common unit. A dollar in this common unit would purchase the same basket of goods in each nation.

After adjusting for population and the purchasing power of national currencies, the United States still spends substantially more per capita than the other industrialized nations portrayed in the figure. For example, in 1994, the United States spent almost three times as much per capita as Great Britain on health.

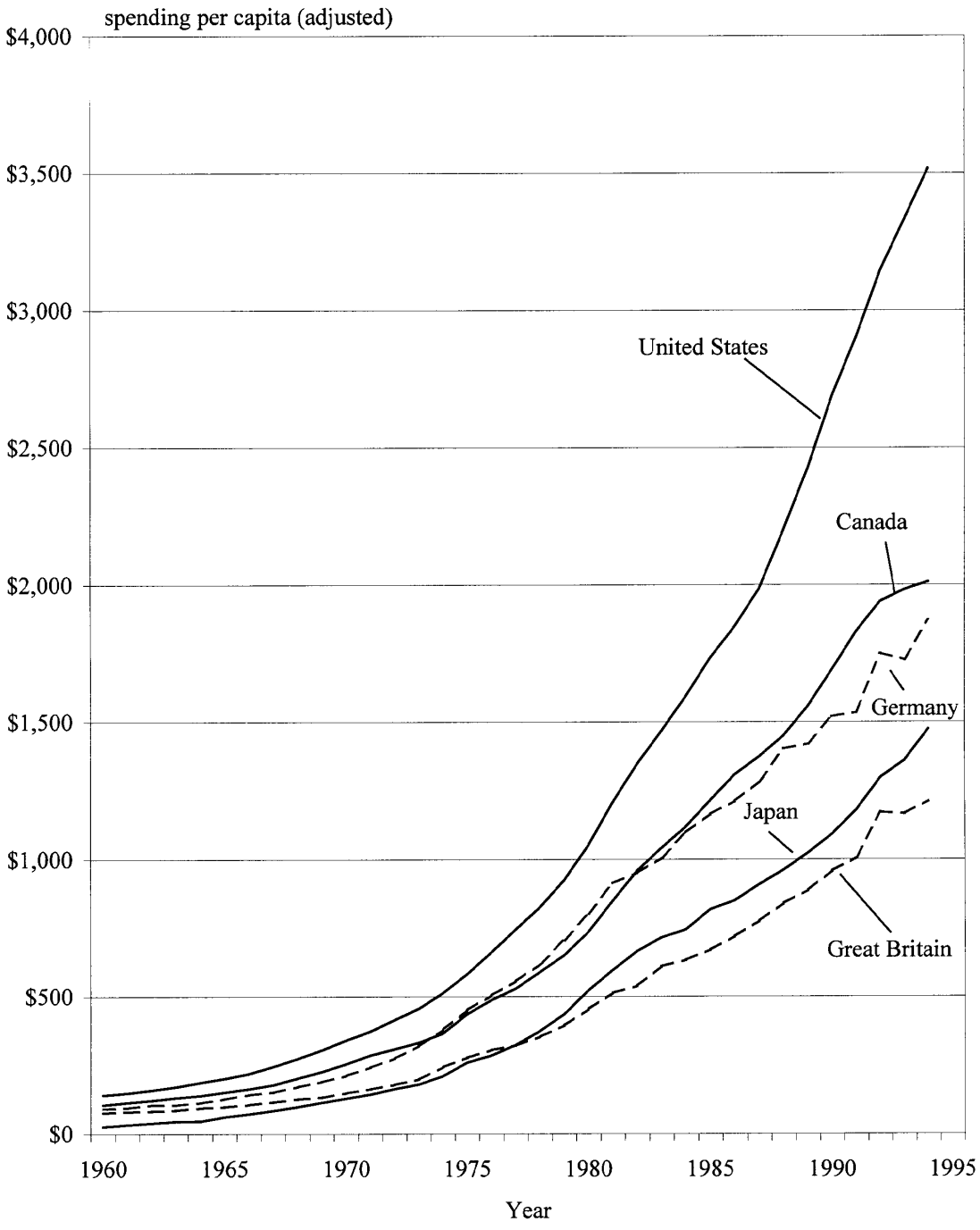
TABLE 1.6. Per Capita Health Spending in Selected Nations, 1960–1994

(Per capita amounts converted to U.S. dollars)

Calendar Year	United States	Great Britain	Canada	Germany	Japan
1960	$141	$77	$105	$91	$26
1965	202	98	151	127	62
1970	341	149	255	212	129
1975	582	278	436	452	260
1980	1,051	453	735	802	522
1985	1,733	670	1,215	1,164	818
1990	2,689	957	1,690	1,519	1,091
1991	2,903	1,006	1,828	1,534	1,180
1992	3,144	1,170	1,939	1,750	1,297
1993	3,329	1,165	1,981	1,726	1,359
1994	3,516	1,211	2,010	1,869	1,473

Note: Table prepared by CRS. All dollar amounts are converted to U.S. dollars using a purchasing price parity measure.

Figure 1.6. Per Capita Health Spending in Selected Nations, 1960-1994



Source: Figure prepared by CRS based on OECD data. Estimates for U.S. based on more more recent National Health Expenditure data, HCFA.

Figure 1.7.
Major Components of Health Expenditures, 1997

Most (89%) but not all health care expenditures are spent on personal health services and supplies. The remaining 11% can be classified into the following categories:

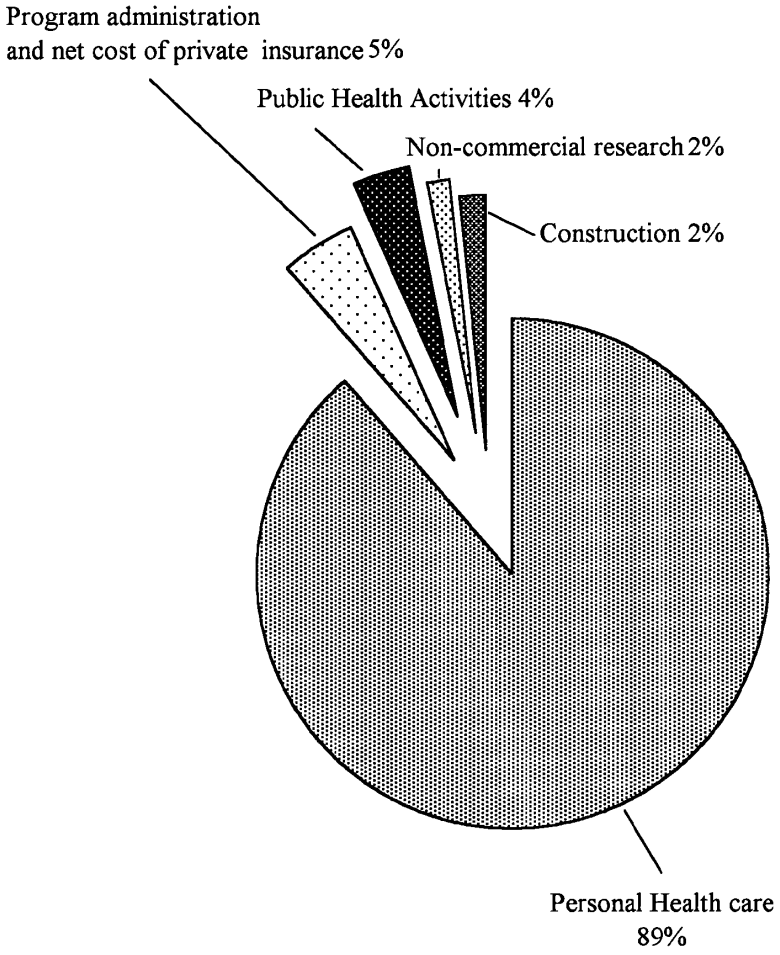
- 4.6% of all health expenditures are for program administration and the net cost of private health insurance (which includes profits earned by private health insurance companies);
- 3.5% of all health expenditures are for public health activities;
- 1.6% of all health expenditures are for non-commercial health research; and
- 1.6% of all health expenditures are for the construction of health care facilities.

TABLE 1.7. Major Components of Health Expenditures, 1997

Spending Category	Expenditures (in millions)	Percent of Total
Personal health care	$969,005	88.7
Program administration and net cost of private insurance	49,998	4.6
Government public health activities	38,490	3.5
Non-commercial research	17,956	1.6
Construction	16,937	1.6
Total health expenditures	$1,092,385	100.0

Note: Table prepared by CRS.

Figure 1.7. Major Components of Health Expenditures, 1997



National Health expenditures = $1,092 billion

Source: Figure prepared by CRS based on data from the Office of the Actuary, Office of National Health Statistics. Total may exceed 100% due to rounding.

Figure 1.8.
Personal Health Care Spending, by Service Category, 1997

Combined spending on three service categories (hospital services, physician services, and nursing home services) account for 69% of total personal health care spending. Inpatient and outpatient hospital service spending represents the single largest service category (38%). In addition, physician service spending accounts for roughly 60% of that amount (23%). Nursing home service spending accounts for about 9% of the total.

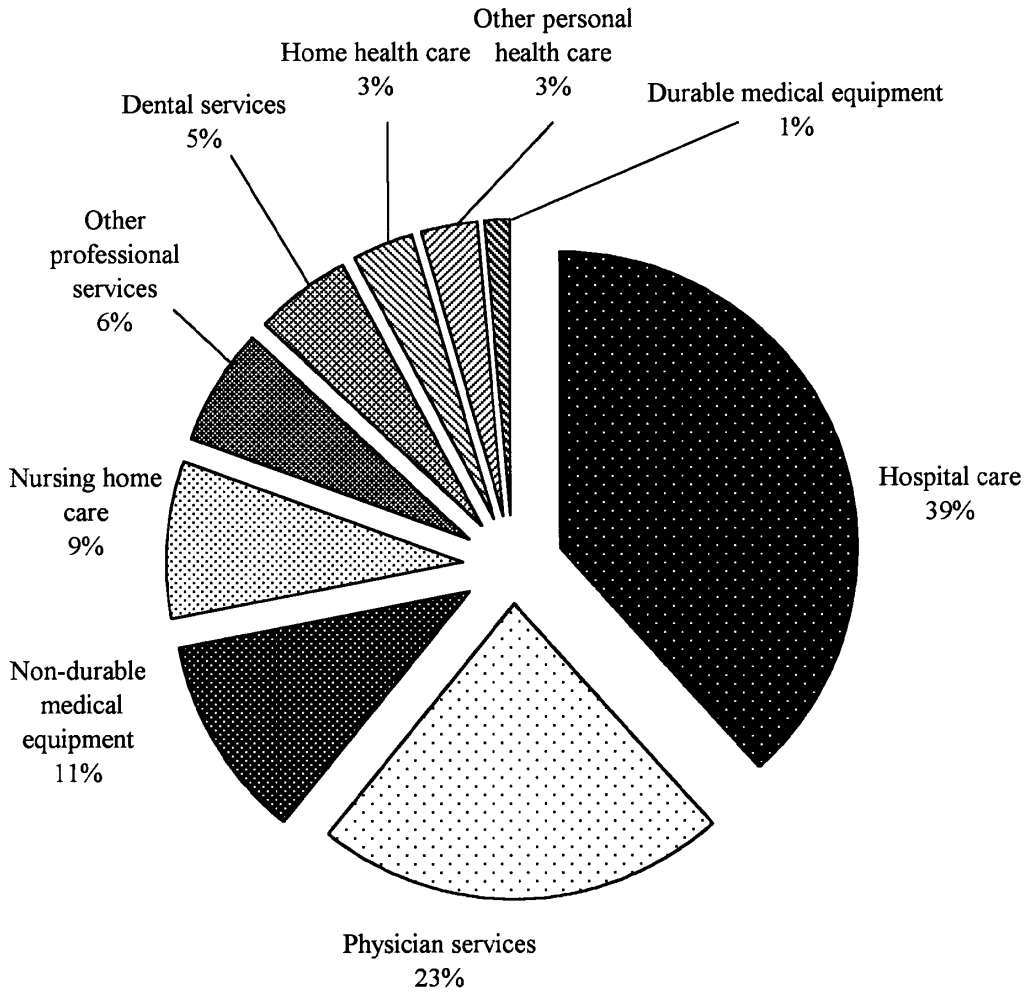
Other significant service or supply categories include prescription drugs (8%), dental services (5%) and a relatively small but growing share home health care services (3%).

TABLE 1.8. Personal Health Care Spending, by Service Category, 1997

Service Category	Expenditures (in millions)	Percent of Total
Hospital care	371,062	38.3
Physician services	217,628	22.5
Non-durable medical products	108,872	11.2
prescription drugs	78,888	8.1
other non-durables	29,984	3.1
Nursing home care	82,774	8.5
Other professional care	61,916	6.4
Dental services	50,648	5.2
Home health care	32,318	3.3
Other personal health care	29,909	3.1
Durable medical equipment	13,878	1.4
Personal health care	$969,005	100.0

Note: Table prepared by CRS.

Figure 1.8. Personal Health Care Spending, by Service Category, 1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, Office of National Health Statistics.

Figure 1.9.
Growth Rates for Hospital, Physician, and Nursing Home Spending, 1960–1997

During the 1990s, the rate of growth for all three major health spending categories (hospital, physician, and nursing home services) was lower than in the past. From 1990 to 1997, hospital and physician spending grew at a relatively moderate rate of 5.4% and 5.8% per annum, respectively. Nursing home services also grew at a lower rate than in prior periods over these 6 years, but at a somewhat higher per annum rate of 7.2%.

A number of factors have contributed to the lowering of growth rates. For instance, the move of much of the population into managed care together with changes in reimbursement practices have contributed to a reduction in inpatient hospital use (see chapter 2) and physician services. In addition, the availability of other alternatives to nursing home care, such as community-based care and special living arrangements for the elderly, may have an impact on the use of nursing home services.

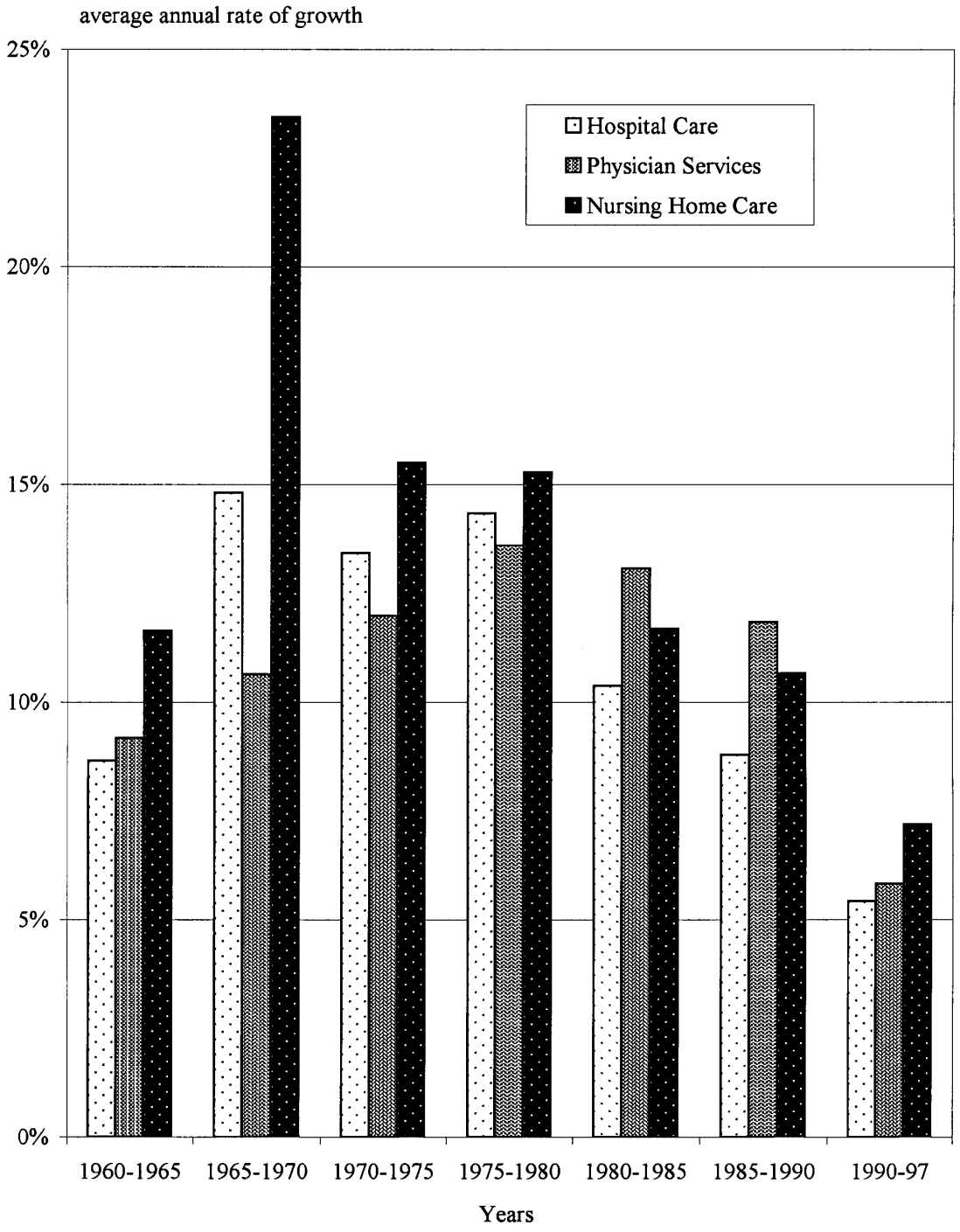
TABLE 1.9. Spending and Annual Growth Rates for Hospital Services, Physician Services, and Nursing Home Services, 1960–1997

(All dollar amounts are in millions)

Calendar Year	Hospital Care	Average Annual Rate of Growth (in percent)	Physician Services	Average Annual Rate of Growth (in percent)	Nursing Home Care	Average Annual Rate of Growth (in percent)
1960	$9,275	—	$5,283	—	$848	—
1965	14,040	8.6	8,191	9.2	1,471	11.6
1970	28,003	14.8	13,579	10.6	4,217	23.4
1975	52,571	13.4	23,909	12.0	8,668	15.5
1980	102,700	14.3	45,232	13.6	17,649	15.3
1985	168,290	10.4	83,618	13.1	30,679	11.7
1990	256,447	8.8	146,346	11.8	50,928	10.7
1995	347,227	6.2	201,863	6.6	75,467	8.2
1996	360,777	3.9	208,509	3.3	79,385	5.2
1997	371,062	2.9	217,628	4.4	82,774	4.3
1990–97 ..	—	5.4	—	5.8	—	7.2

Note: Table prepared by CRS.

Figure 1.9. Growth Rates for Hospital, Physician, and Nursing Home Spending, 1960-1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, Office of National Health Statistics, HCFA.

Figure 1.10.
Sources of Hospital Service Payments, 1960–1997

In 1997, public (federal and state and local) sources accounted for over 61% of hospital service expenditures. The single largest hospital services payer is the federal government, contributing half of the total spending for this service category. Private health insurance represents the next largest payer paying about 31% of all hospital spending.

Between 1960 and 1997, federal payments grew from 17% to 50% of hospital spending. Medicare and Medicaid's enactment led to this increase in federal spending and the reduction in out-of-pocket spending.

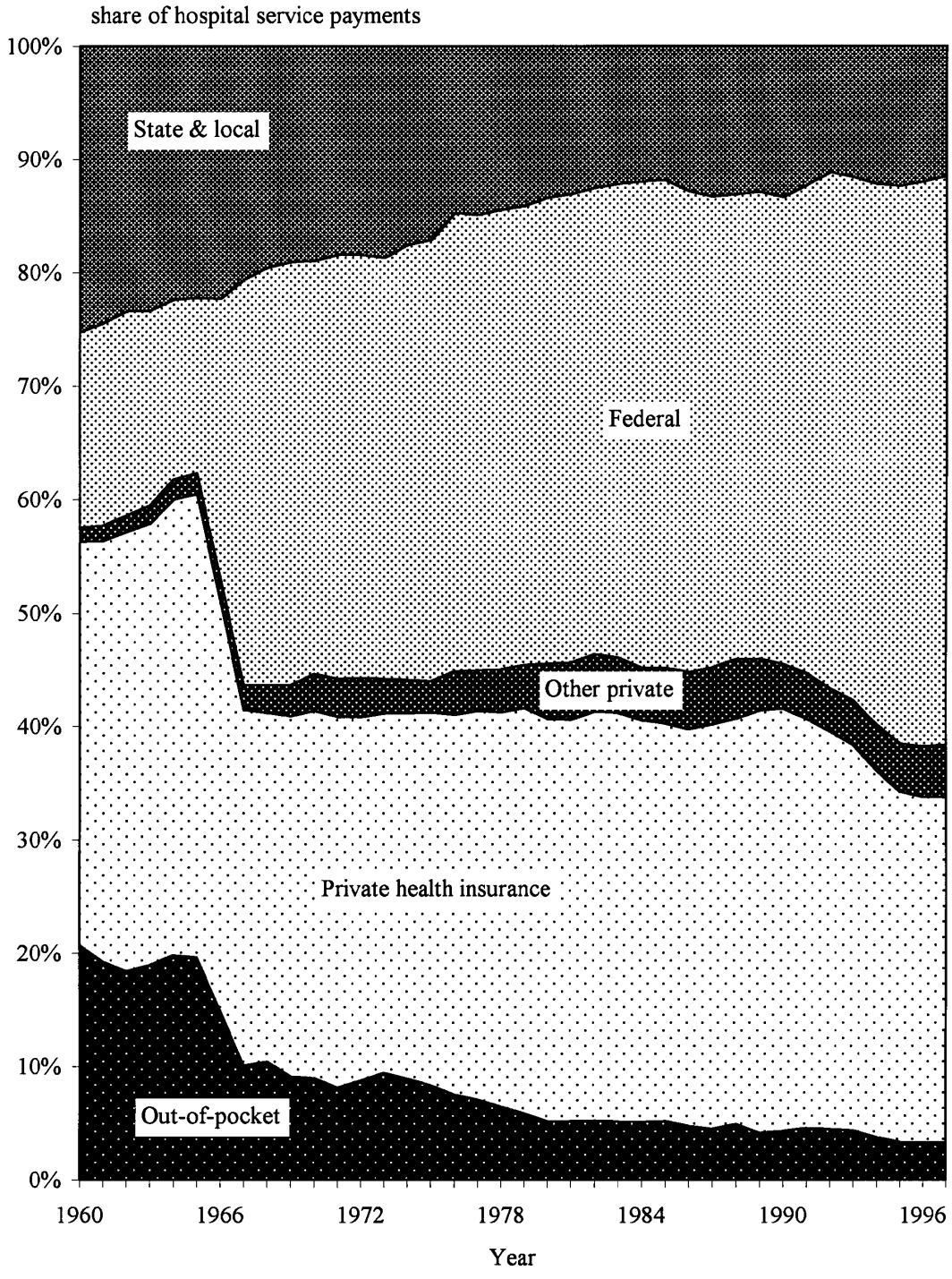
TABLE 1.10. Sources of Hospital Service Payments, 1960–1997

(in percent)

Calendar Year	Out-of-Pocket Payments	Private Health Insurance	Other Private	Federal Spending	State and Local Spending	Total Expenditures (in millions)
1960	20.7	35.6	1.2	17.3	25.2	$9,275
1965	19.6	40.9	1.9	15.4	22.2	14,040
1970	9.0	32.4	3.2	36.4	19.0	28,003
1975	8.3	32.9	2.7	38.9	17.1	52,571
1980	5.2	35.5	4.9	41.0	13.4	102,700
1985	5.2	35.0	4.9	43.0	11.9	168,290
1990	4.3	37.3	4.0	41.1	13.3	256,447
1995	3.3	30.9	4.3	49.1	12.4	347,227
1996	3.3	30.5	4.5	49.8	12.0	360,777
1997	3.3	30.5	4.6	50.0	11.5	371,062

Note: Table prepared by CRS.

Figure 1.10. Sources of Hospital Service Payments, 1960-1997



Source: Figure prepared by CRS based on data from the Office of the Actuary, Office of National Health Statistics.

Figure 1.11.
Total Hospital Marginal Revenues, 1976–1997

Hospital margins are a widely used indicator of the financial condition of the nation's hospitals. A hospital's total margin is the difference between the hospital's total revenues and total expenses, taken as a percentage of total revenues. Medicare's prospective payment system (PPS) hospital inpatient margins are the difference between PPS operating and capital payments the hospital receives and the sum of its Medicare inpatient operating and capital costs, taken as a percentage of the total Medicare payments.

Figure 1.11 shows the trend in total hospital margins. Between 1976 and 1984, total hospital revenues increased at a faster rate than total hospital expenses, resulting in increasing total hospital margins. In 1984, total margins peaked at 7.3%. Between 1985 and 1988, total margins declined to 3.5%, the lowest level since the enactment of PPS. Since 1985, total hospital margins have been gradually increasing, reaching 5.7% in 1995. The implementation of Medicare's PPS for hospital care in 1984, under which the program began paying only a fixed amount for each admission, has been credited with motivating hospitals to contain their costs. Between 1984 and 1991, PPS margins dropped each year, reaching −2.4% in 1991. Since 1992, PPS margins have started climbing upward, and are projected to reach 14.2% in 1997.

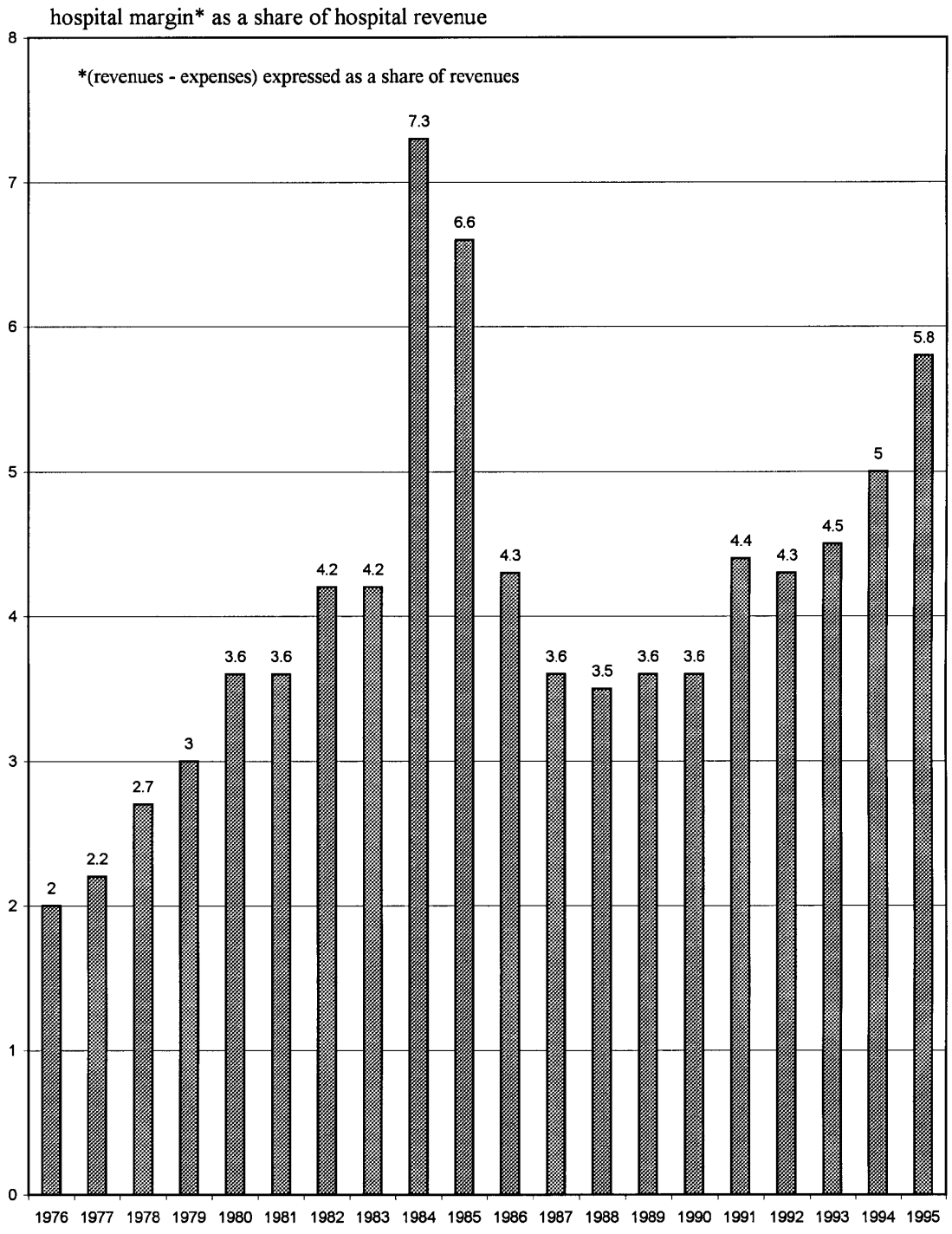
TABLE 1.11. Total Hospital Marginal Revenues, 1976–1997

Calendar Year	Total Aggregate Margin	Actual and Projected PPS Inpatient Margins
1976	2.0%	—
1980	3.6	—
1984	—	13.4%
1985	6.6	13.0
1986	—	8.7
1987	—	5.9
1988	—	2.7
1989	—	0.3
1990	3.6	−1.5
1991	4.4	−2.4
1992	4.3	−1.0
1993	4.5	1.0
1994	5.0	5.0
1995	5.8	10.0
1996	—	11.3*
1997	—	14.2*

Note: Table prepared by CRS.

*MedPAC Estimated data. March 1998.

Figure 1.11. Total Hospital Marginal Revenues, 1976-1997



Source: Figure prepared by CRS based on esimates prepared by the Medicare Payment Advisory Commision.

Figure 1.12.
Trends in Hospital Utilization: Inpatient Days and Outpatient Visits, 1965–1997

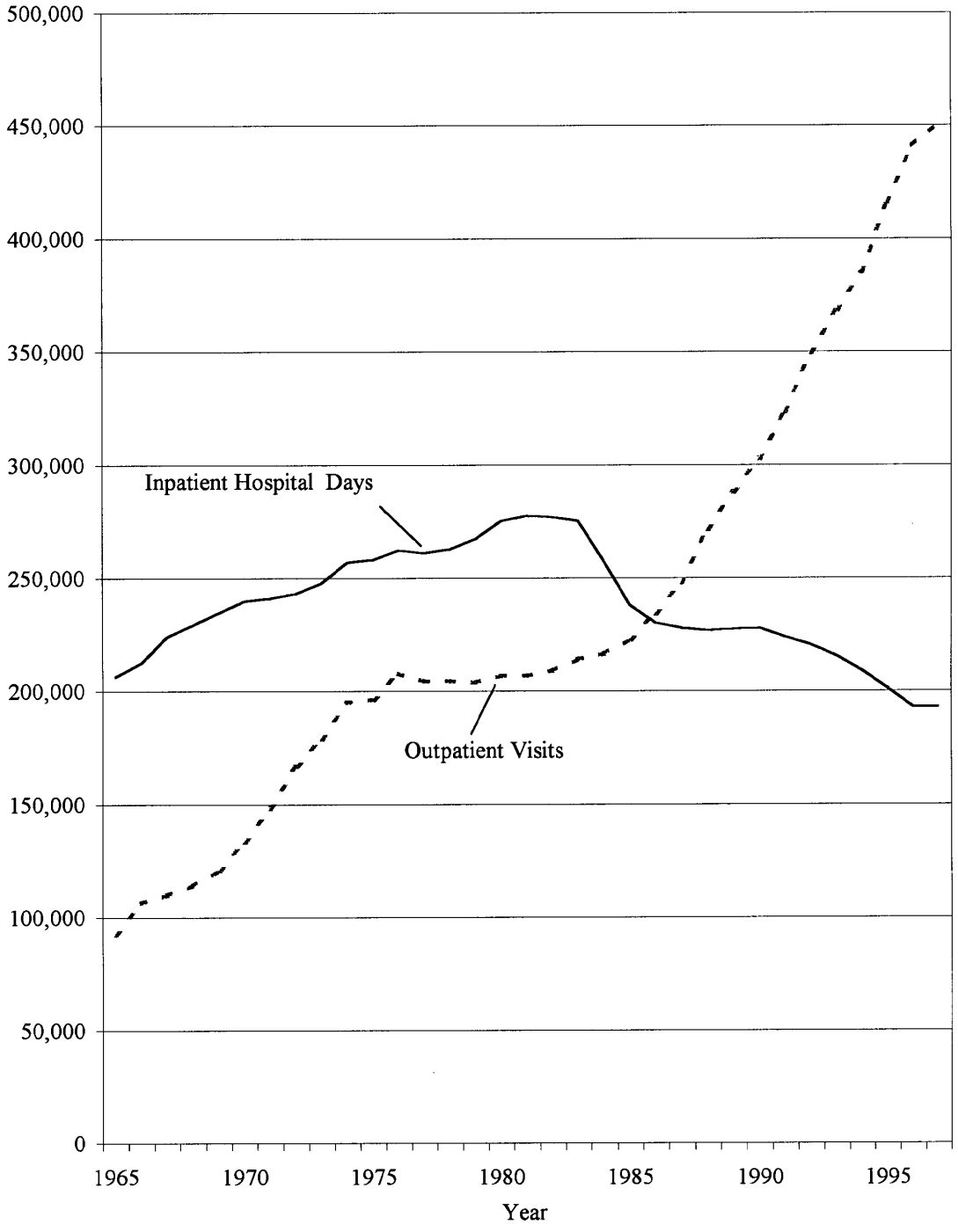
Spending on hospital services includes spending for inpatient care and outpatient visits. Figure 1.12 depicts a major shift in the use of these two categories of hospital services. Inpatient hospital days (an aggregate measure influenced by the number of admissions and the length of hospital stays) declined during the 1980s and has continued to decline. Between 1990 and 1997, inpatient days declined by 15%. In contrast, the number of outpatient visits has increased over this time period, rising by 49%.

TABLE 1.12. Trends in Hospital Utilization: Inpatient Days and Outpatient Visits, 1965–1997

Calendar Year	Outpatient Visits	Inpatient Days
1965	92,631	206,411
1970	133,545	239,866
1975	196,311	258,096
1980	206,752	275,105
1985	222,773	237,857
1990	302,691	227,782
1991	323,202	223,805
1992	349,397	220,476
1993	368,358	215,390
1994	384,880	209,025
1995	415,710	201,279
1996	440,845	192,919
1997	450,907	192,730

Note: Table prepared by CRS.

Figure 1.12. Trends in Hospital Utilization: Inpatient Days and Outpatient Visits, 1965-1997



Source: Figure prepared by CRS based on data from the American Hospital Association. Figures are for Total non-Federal short-term general or speciality hospitals.

Figure 1.13.
Sources of Physician Services Payments, 1960–1997

Private insurance is the major source of spending for physician services paying for half of all physician services in 1997. Another roughly $1 in $7 spent on physician services in the United States is paid directly by individuals out-of-pocket either in the form of copayments, deductibles, or in-full for services that are not covered by their health insurance.

Like hospital services, the probability of individuals paying for physician services has declined sharply since the 1960s. Unlike hospital services, however, the single largest payer for physician services is not the federal government, but rather private health insurance companies. Private health insurers paid for 51% of all physician services in 1997; in 1985, private health insurers contributed to about 40% of the total.

In contrast to these shifts in private payment sources, public sources of physician payments has remained relatively stable over the last 10 years. The federal government's share of this spending increased slightly (from 23% to 27%), while state and local spending continued to pay for about 6% of all physician services.

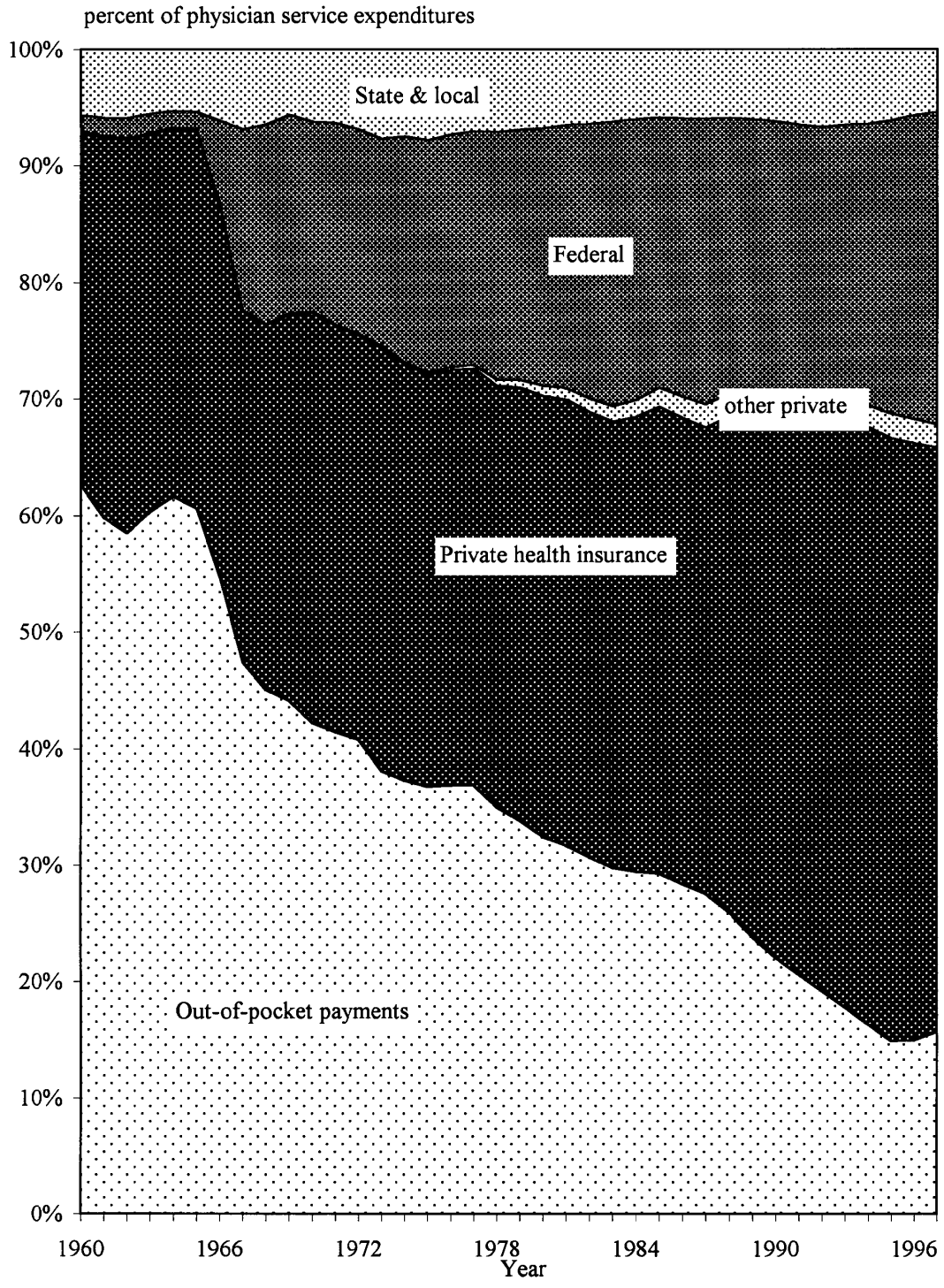
TABLE 1.13. Sources of Physician Services Payments, 1960–1997

(in percent)

Calendar Year	Out-of-Pocket Payments	Private Health Insurance	Other Private	Federal Spending	State and Local Spending	Total Expenditures (in millions)
1960	62.7	30.2	0.1	1.4	5.7	$5,283
1965	60.6	32.5	0.1	1.4	5.4	8,191
1970	42.2	35.2	0.1	16.3	6.2	13,579
1975	36.7	35.3	0.2	19.9	7.8	23,909
1980	32.4	37.9	0.8	22.1	6.8	45,232
1985	29.2	40.1	1.6	23.2	5.9	83,618
1990	22.0	45.7	1.8	24.3	6.2	146,346
1995	14.9	51.7	2.1	25.2	6.1	201,863
1996	14.9	51.3	2.0	26.1	5.7	208,509
1997	15.7	50.2	2.0	26.8	5.4	217,628

Note: Table prepared by CRS.

Figure 1.13. Sources of Physician Services Payments, 1960-1997



Source: Figure prepared by CRS based on data from the Office of Actuary, Office of National Health Statistics

Figure 1.14.
Physician Contacts Per Person, 1987–1995

Largely as a result of an increase in the number of visits by the aged, the number of physician contacts per person has increased from 5.4 contacts per person per annum in 1987 to 5.8 contacts per annum per year in 1995.

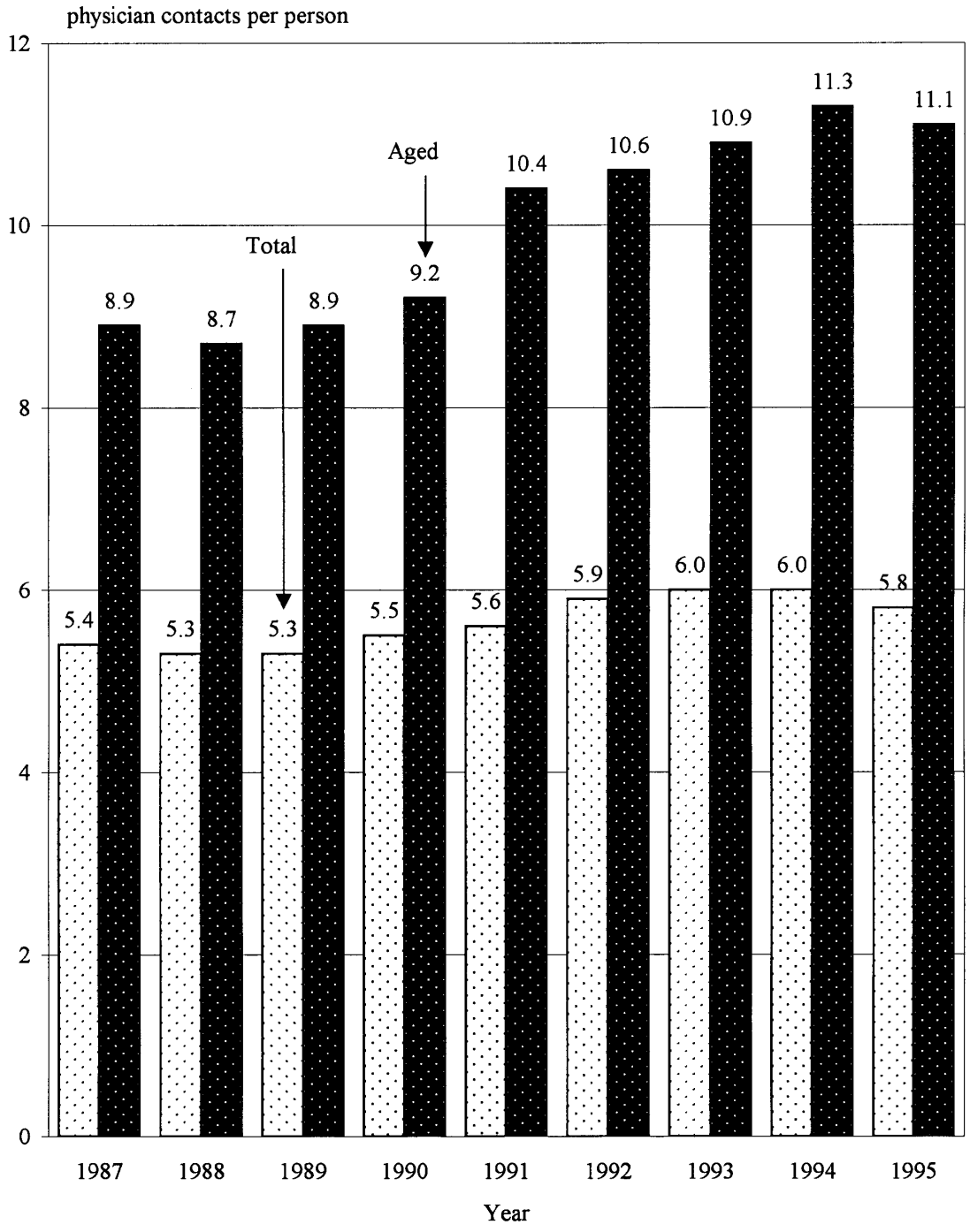
For the elderly, the number of physician contacts increased from 8.9 contacts per year in 1989 to 11.3 contacts per person in 1994. The most recent data, for 1995, indicate a slight decline in these contacts to 11.1.

TABLE. 1.14. Physician Contacts Per Person, 1987–1995

Year	Total	Aged
1987	5.4	8.9
1988	5.3	8.7
1989	5.3	8.9
1990	5.5	9.2
1991	5.6	10.4
1992	5.9	10.6
1993	6.0	10.9
1994	6.0	11.3
1995	5.8	11.1

Note: Table prepared by CRS.

Figure 1.14. Physician Contacts Per Person, 1987-1995



Source: Figure prepared by CRS based on data from the National Center for Health Statistics. Data from National Health Interview Survey.

Figure 1.15.
Physician Supply, Selected Years 1965–1997

Since the 1960s the number of physicians in the United States has grown rapidly. In 1965, 266,000 physicians (excluding those physicians practicing in federal health systems) provided services to the U.S. population. By 1975, the number of physicians increased to 357,000. By 1997, there were close to 736,000 physicians in the United States, more than 2.7 times the number in 1965.

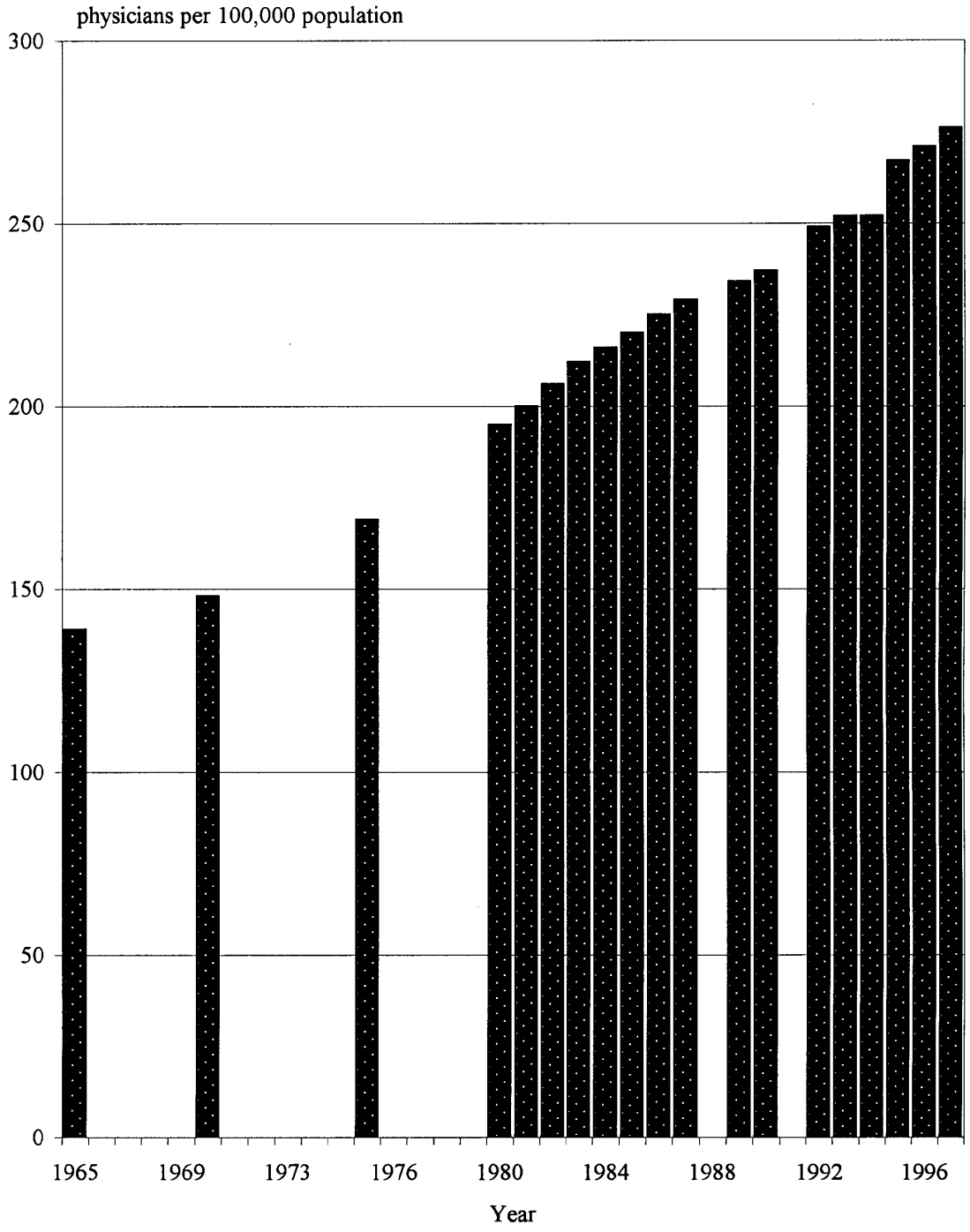
As shown in figure 1.15, the increase in the number of physicians has outpaced population growth in the United States. A recent Institute of Medicine report indicates that the physician growth rate is about 1½ times the rate of population growth. It should be noted that this overall growth rate masks significant differences in the physician to population ratio in specific geographic regions.

TABLE 1.15. Physician Supply, Selected Years 1965–1997

Year	Number of Physicians Per 100,000 Population
1965	139
1970	148
1975	169
1980	195
1985	220
1990	237
1992	249
1993	252
1994	252
1995	267
1996	271
1997	276

Note: Table prepared by CRS.

Figure 1.15. Physician Supply, Selected Years 1965-1997



Source: Figure prepared by CRS based on data from the American Medical Association. Rates are for non-federal physicians.

Figure 1.16.
Sources of Nursing Home Care Payments, 1960–1997

The federal government's role as a source of payment for nursing home care has changed in the last few years. In 1990, the federal government paid for 31% of care; by 1997, its share increased to about 42%. As depicted in the figure, no other single payment source experienced a similar increase in share of nursing home payments.

The Nation spent $83 billion for nursing home care in 1997. Government programs financed the largest portion of this, with Medicaid (federal and state spending) playing the largest role. Medicare's role as a payer for nursing home care has increased in the last several years and accounts for much of the increase in the federal government's share of nursing home spending. Out-of-pocket spending is the other major source of payment for nursing home care, and private insurance coverage of nursing home services is currently very limited.

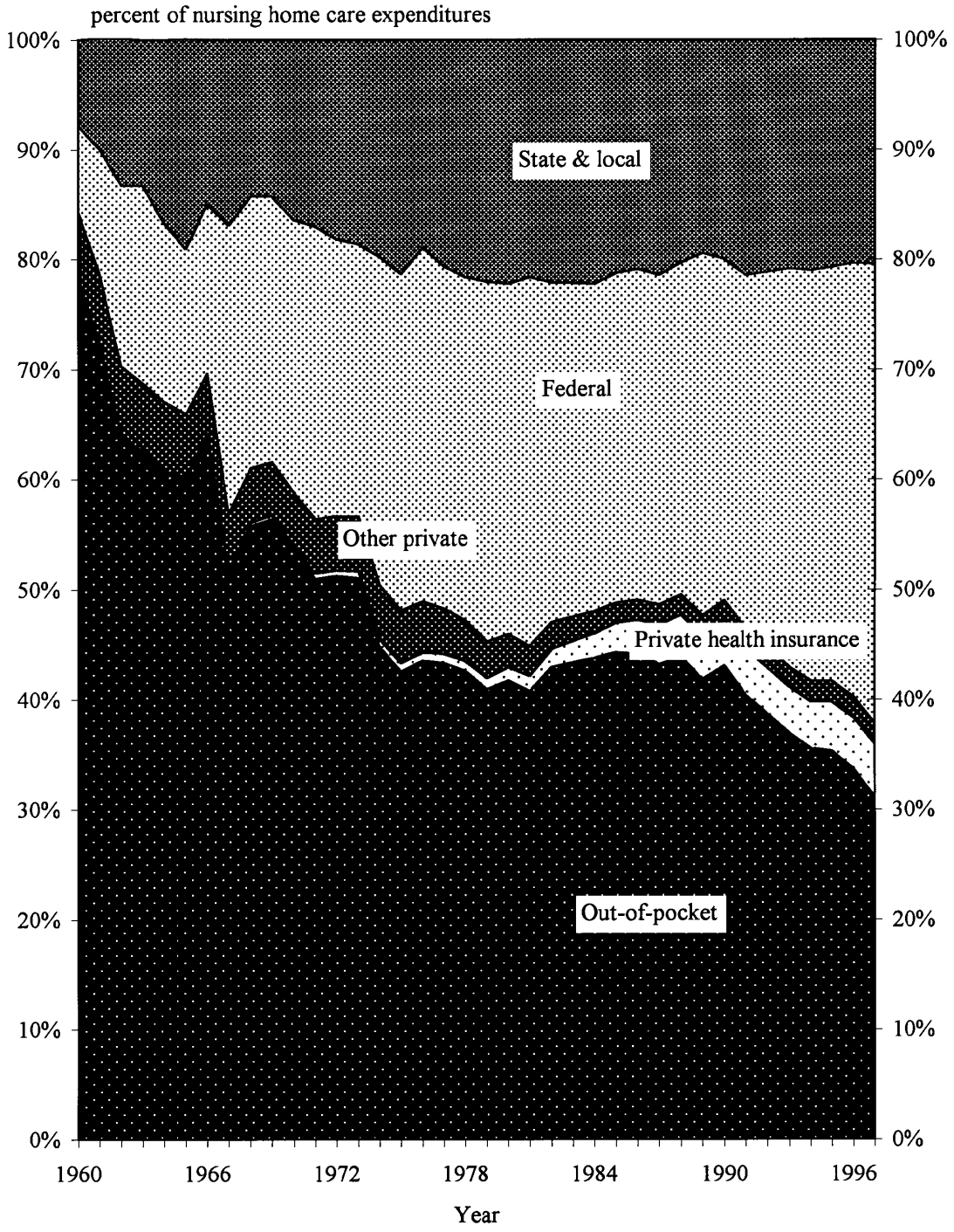
TABLE 1.16. Sources of Nursing Home Care Payments, 1960–1997

(in percent)

Calendar Year	Out-of-Pocket Payments	Private Health Insurance	Other Private	Federal Spending	State and Local Spending	Total Expenditures (in millions)
1960	77.9	0.0	6.4	7.9	7.8	848
1965	60.1	0.1	5.7	15.0	19.0	1,471
1970	53.5	0.4	4.9	24.8	16.4	4,217
1975	42.6	0.7	4.8	30.5	21.3	8,668
1980	41.8	1.2	3.0	31.8	22.2	17,649
1985	44.4	2.7	1.8	29.9	21.2	30,679
1990	43.1	4.0	1.8	31.0	20.0	50,928
1995	35.3	4.5	1.9	37.6	20.7	75,467
1996	33.6	4.7	1.9	39.4	20.4	79,385
1997	31.1	4.9	1.9	41.7	20.4	82,774

Note: Table prepared by CRS.

Figure 1.16. Sources of Nursing Home Care Payments, 1960-1997



Source: Figure prepared by CRS based on data from Office of the Actuary, Office of National Health Statistics

Figure 1.17.
Nursing Home Use by the Aged, 1973–1995

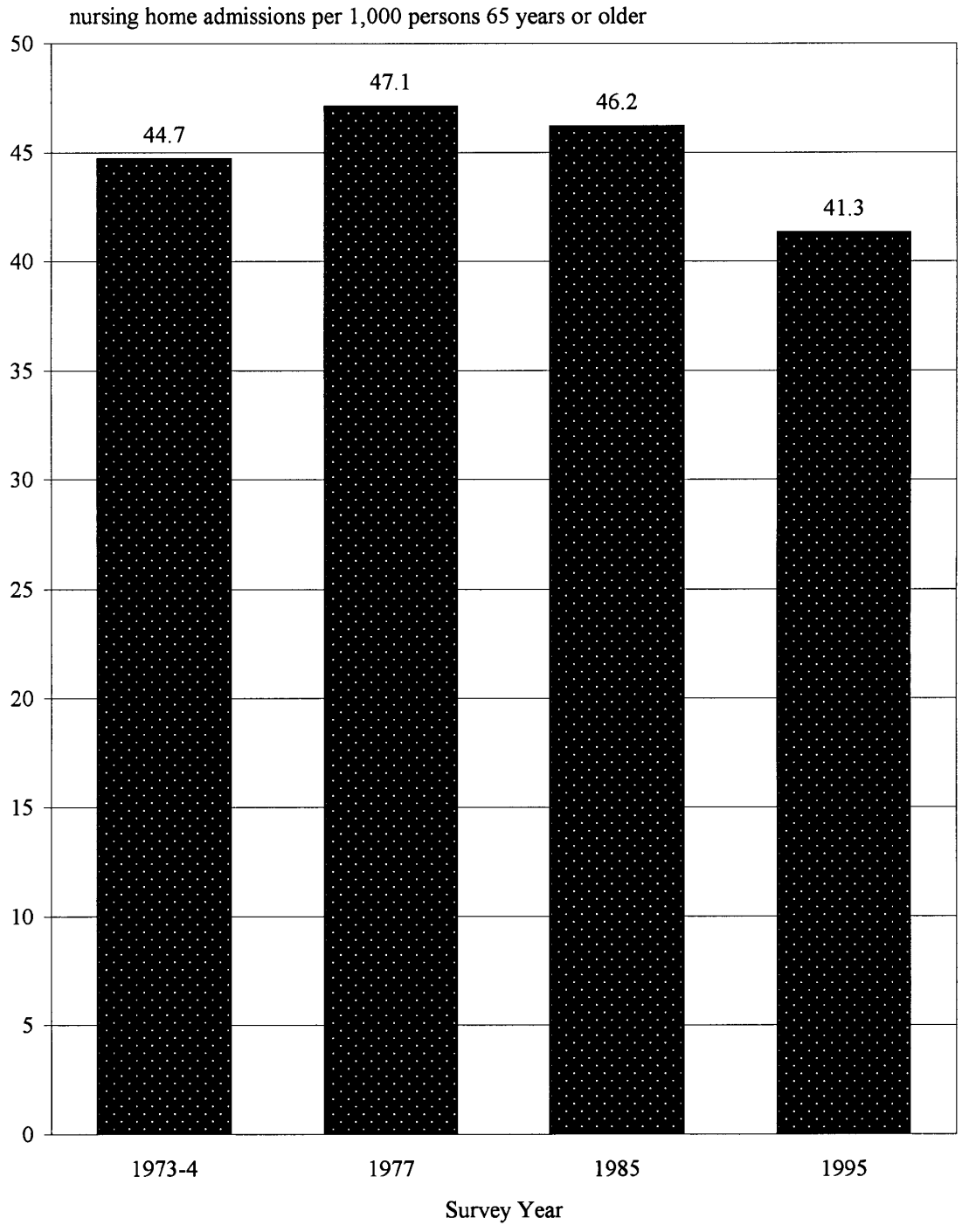
A recent survey finds that the rate of nursing home use among the aged has declined since the mid–1970s. In 1985, 4.6% of the aged were residents in nursing homes. In 1995, this percentage fell to 4.1%. This reduction is occurring at the same time that the aged population is growing in size and becoming much older. One possible explanation for this decline in the use of nursing home services is the growing use of alternative sources of long-term care services for the aged. For instance, the Medicare program's expansion of coverage of home health services may have contributed to this lower nursing home utilization rate among the aged. States have also expanded coverage of home and community-based care under their Medicaid programs.

TABLE 1.17. Nursing Home Use by the Aged, 1973–1995

Year	Rate (Per 1,000)
1973–1974	44.7
1977	47.1
1985	46.2
1995	41.3

Note: Table prepared by CRS.

Figure 1.17. Nursing Home Use by the Aged, 1973-1995



Source: Figure prepared by CRS based on NCHS, National Nursing Home Survey data.

Section 2.
Insurance and the Uninsured

How many Americans are without health insurance? Where do they live and work? How old are they? This section of the chartbook describes the economic and demographic characteristics of the uninsured. It also describes two aspects of the health sector in the United States: the sources of coverage among the 226 million Americans who are insured and how that coverage is changing.

In addition to providing basic information on the pattern of health insurance coverage, this section reports on children without health insurance. The proportion of children with no health insurance rose from 13.3% in 1990 to 15.4% in 1997, and the number of uninsured children increased by almost 2.5 million during the period.

Different data sources provide different answers to the question: how many Americans are without health insurance? The estimates contained in this section of the report are based on an analysis of the March 1998 income supplement of the Current Population Survey (CPS) prepared by the Census Bureau. This survey asks a series of questions on the health insurance coverage of individuals and families for the prior calendar year (1997). The estimates contained in this section follow the methods used by the Census Bureau in their calculation of the number of uninsured.

This section also provides background information on the use of managed care options by those with insurance. Managed care can take a variety of forms including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). This topic concludes with a series of figures portraying the use of the different types of HMOs, health service utilization of HMO members, and PPO enrollment and ownership.

In addition, this section includes detailed information on state regulations of health insurance. State laws regulating managed care through a variety of provisions, such as any willing provider and mental health parity, are described. State laws regulating the health insurance premiums that may be charged for individual, nongroup health insurance, such as community rating, are outlined. Finally, details are reported for state high-risk health insurance pools.

Figure 2.1.
Health Insurance Coverage by Type of Insurance, 1997

Figure 2.1 provides a breakdown of health insurance coverage by type of insurance. It should be noted in viewing the figure that individuals may have more than one source of health insurance. Based on the annual income supplement to the Current Population Survey, conducted by the Bureau of the Census:

- 63% of the U.S. population relied on employment-based health insurance coverage (group health insurance through an employer or union);
- 22% of the U.S. population relied on Medicare or Medicaid as a source of health insurance; and
- 10% of the U.S. population relied on private nongroup coverage to meet their health insurance needs.

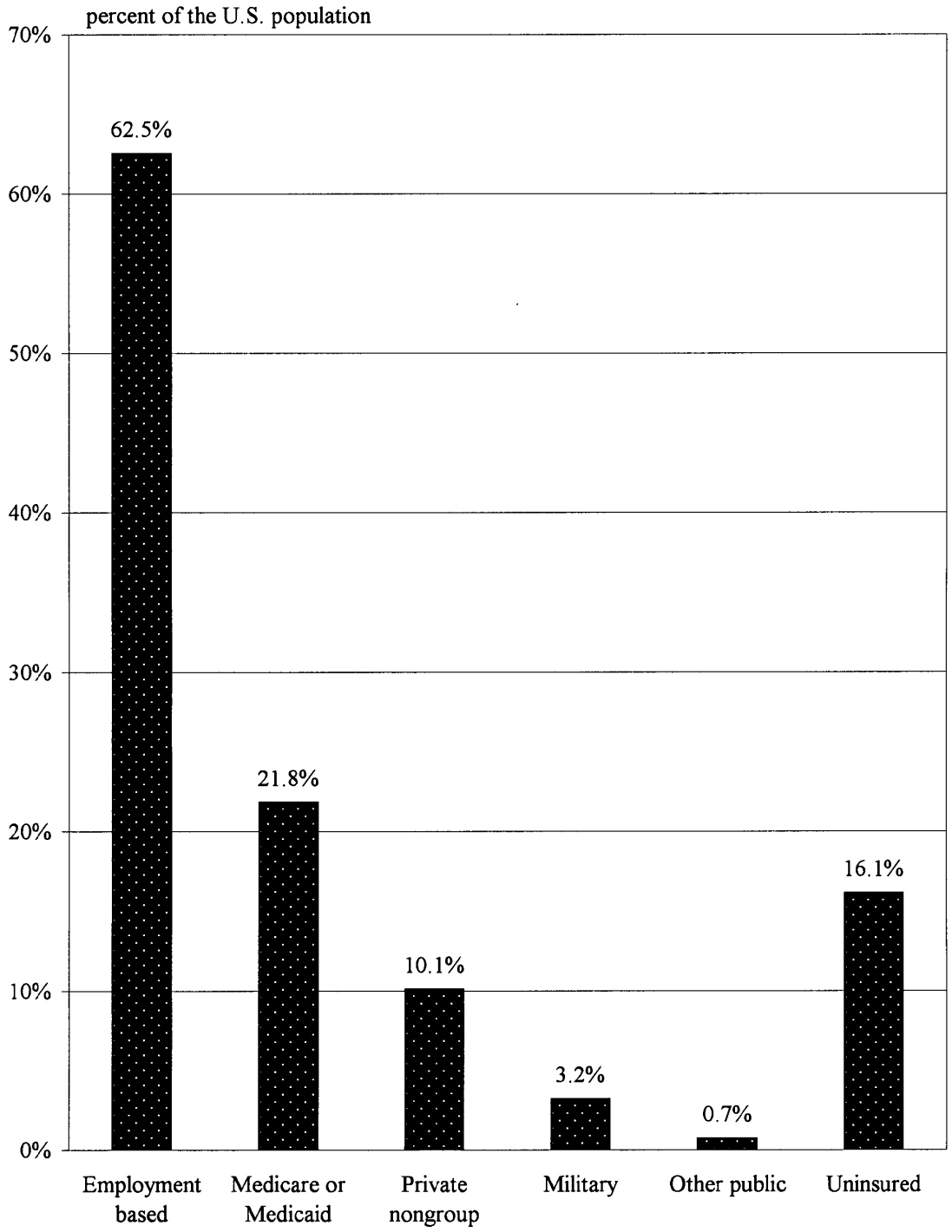
In 1997, approximately 43 million people in the United States (16.1%) were without any form of health insurance coverage throughout the year. The uninsured were often young and poor, but many of them did have some ties to the labor force, frequently in small firms.

TABLE 2.1. Health Insurance Coverage by Type of Insurance, 1997

Type of Health Insurance	Percent of U.S. Population
Employment based	62.5
Medicare or Medicaid	21.8
Private nongroup	10.1
Military	3.2
Other public	0.7
Uninsured	16.1
Total population (in millions)	269.1

Note: Table prepared by CRS. It should be noted in viewing the figure that individuals may have more than one source of health insurance.

Figure 2.1. Health Insurance Coverage by Type of Insurance, 1997

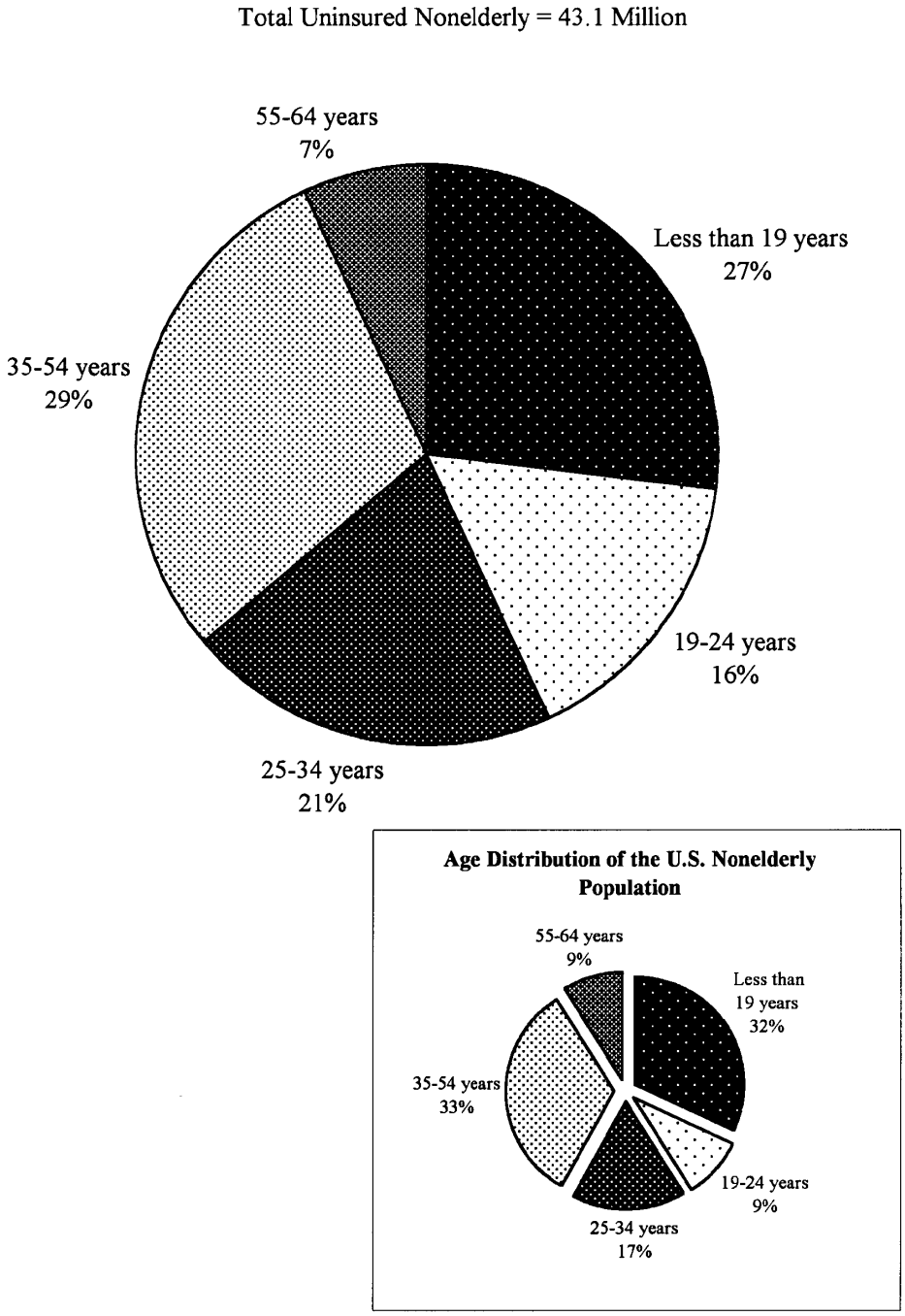


Source: CRS analysis of data from the March 1998 Current Population Survey (CPS).

Figure 2.2.
Uninsured Nonelderly by Age, 1997

Figure 2.2 provides a breakdown of the uninsured population by age. Note that this figure excludes the elderly population ages 65 and over, most of whom are insured. Persons ages 19 to 34 years are over-represented among the uninsured, especially young adults ages 19 to 24. These young adults comprise 16% of the uninsured population, but only 9% of the total nonelderly population. Children less than 19 years and adults ages 35 to 64 make up smaller proportions of the uninsured than of the total nonelderly population.

Figure 2.2. Uninsured Nonelderly by Age, 1997



Source: Chart prepared by CRS based on analysis of the Current Population Survey, March 1998.

Figure 2.3.
Uninsured Ages 35–64

Figure 2.3 shows the percent uninsured by working status for people ages 35 to 64. Across age groups, the pattern of uninsurance is quite similar when work status is controlled. The highest rate of uninsurance is found among those in the "other" category, which includes students, homemakers, those reporting that they were unable to find work, and other circumstances. The lowest rate of uninsurance is reported by full-time full year workers in each age category.

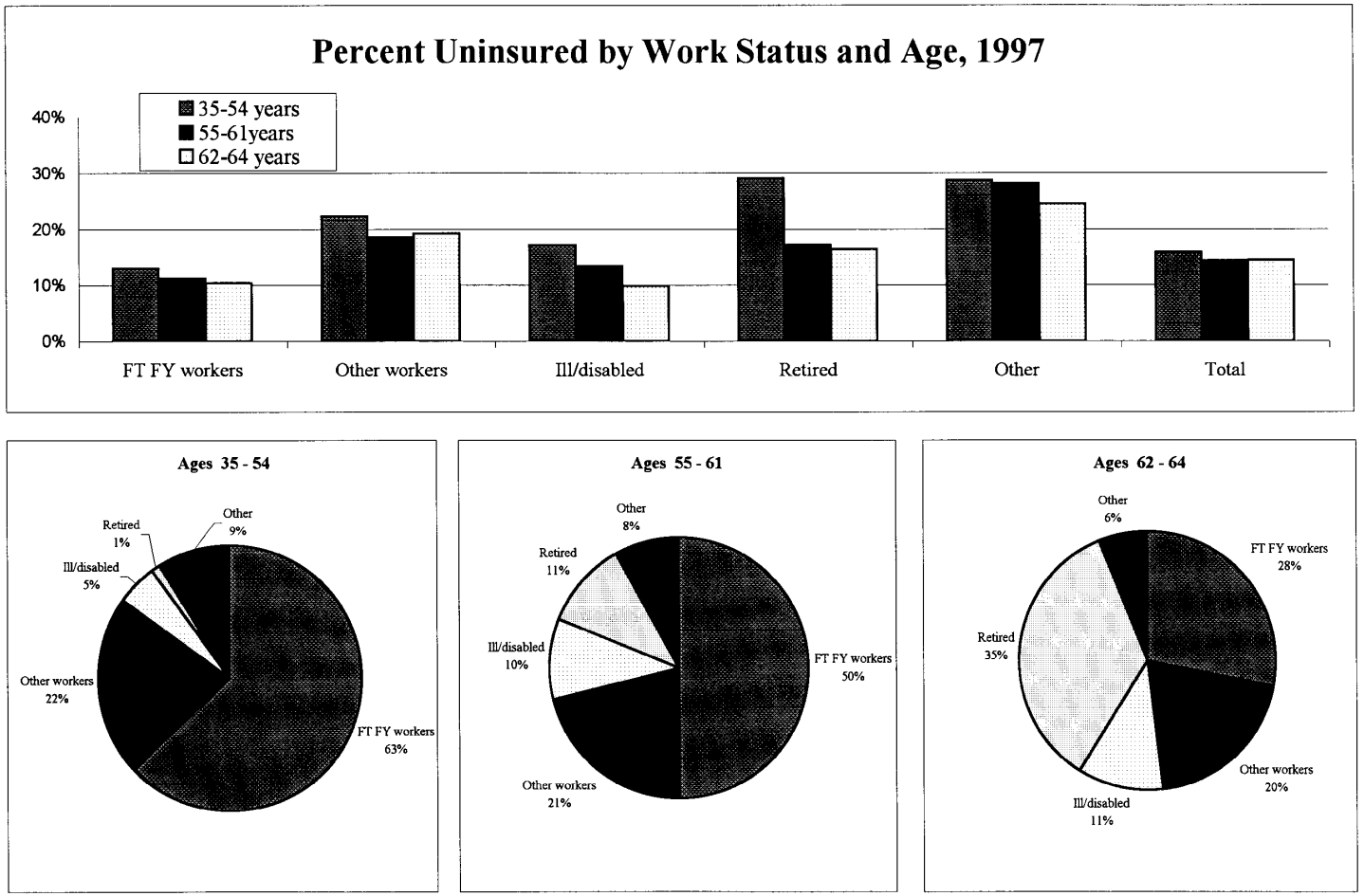
Within each work status, lack of coverage is highest for people ages 35 to 54, both in each group and in total. At the same time, people ages 62 to 64 and 55 to 61 are slightly less likely to be uninsured than the younger group—14.3 to 14.4% versus 15.8%. This result occurs because of the differences in work status by age group. Almost two-thirds (63%) of those ages 35 to 54 work full-time compared to 50% of those ages 55 to 61 and 28% of those ages 62 to 64. High rates of coverage among full-time workers reduce the relative lack of coverage among the youngest age group here. Moreover, early retirees, who account for 35% of those ages 62 to 64 but only 1% of those ages 35 to 54, are more likely to be uninsured than full-time workers. Relatively fewer full-time workers and more retirees among those ages 62 to 64 produce the level of uninsurance found for this group.

TABLE 2.3. Percent Uninsured by Work Status and Age, 1997

	Full-Time Full Year Workers	Other Workers	Ill/Disabled	Retired	Other	Total
35–54 years	11.2%	23.6%	17.2%	29.1%	28.7%	15.8%
55–61 years	9.8%	18.7%	13.4%	17.2%	28.1%	14.3%
62–64 years	9.6%	17.2%	9.8%	16.4%	24.5%	14.4%

Source: Table prepared by CRS using the March 1998 CPS.

Figure 2.3. Uninsured Ages 35 - 64

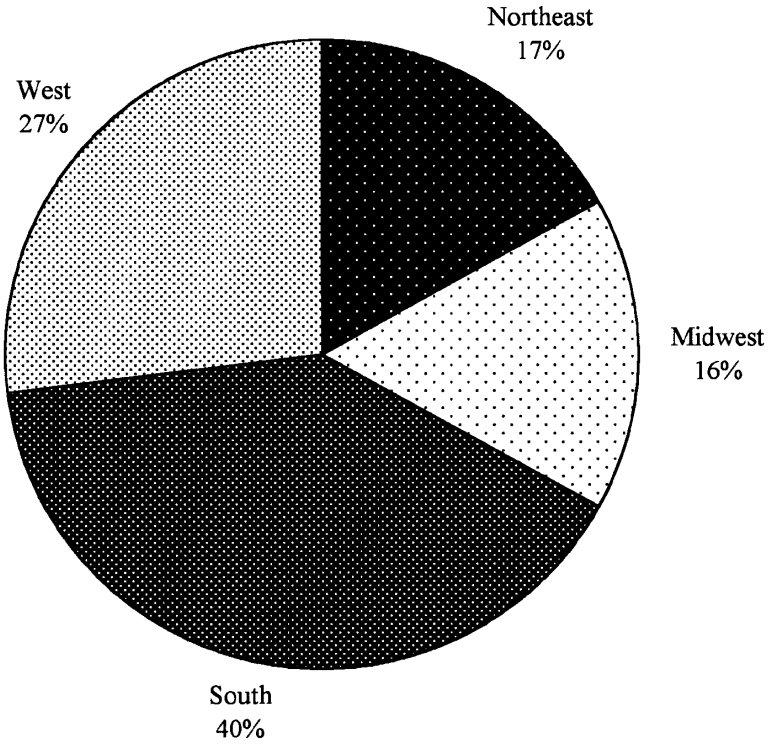


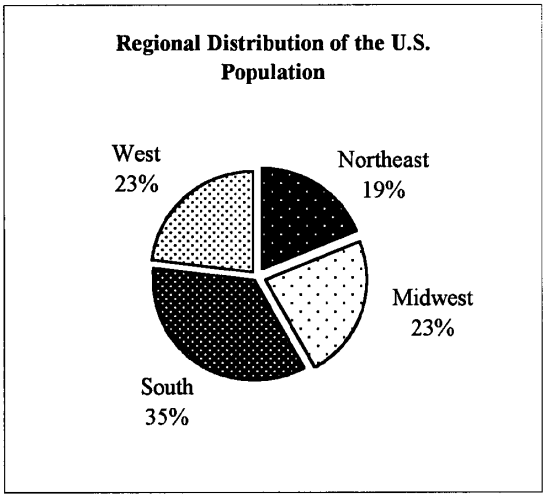
Source: Figure prepared by CRS based on analysis of Current Population Survey, March 1998.

Figure 2.4.
Uninsured by Region of Residence, 1997

People living in the Northeast and Midwest are less likely to be uninsured than those in the West and South. While residents of the Northeast and Midwest make up 19% and 23%, respectively, of the U.S. population, they constitute only 17% and 16% of persons without health insurance. In contrast, while the South contains 35% of the U.S. population, 40% of all people without health insurance reside in the South. Likewise, while 23% of U.S. residents live in the West, 27% of all people without health insurance live in Western states.

Figure 2.4. Uninsured by Region of Residence, 1997





Source: Chart prepared by CRS based on analysis of Current Population Survey, March 1998.

Figure 2.5.
Sources of Children's Health Insurance, 1990 and 1997

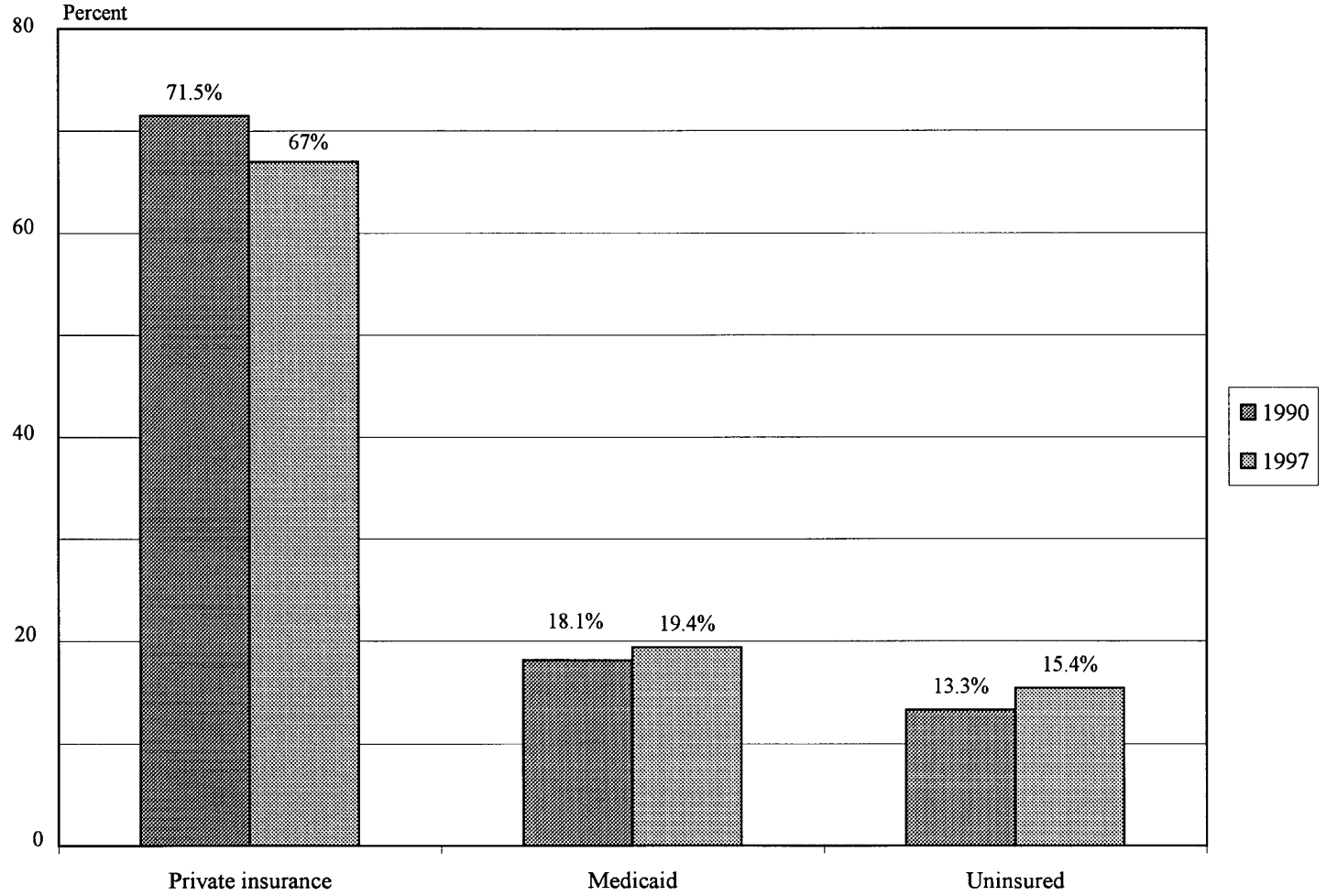
Figure 2.5 shows the percentage of children ages 18 and younger who were covered by private insurance or Medicaid or who were uninsured in 1990 and 1997. According to data collected in the Current Population Survey (CPS), the number of children with private health insurance—employer-group coverage or individually purchased policies—rose by about 1.5 million from 1990 to 1997, but the percentage of children with private health insurance declined from 71.5% to 67.0%. Simultaneously, the percentage of children covered by Medicaid increased from 18.1% to 19.4%. Consequently, the proportion of children with no health insurance rose from 13.3% in 1990 to 15.4% in 1997, and the number of uninsured children increased by almost 2.5 million during this period. Care should be exercised in interpreting these data because changes to the survey instrument and data collection methods in the intervening years may have affected the estimates of insurance coverage derived from this source. Nevertheless, while the precise size of the changes in insurance coverage from year to year may be uncertain, the trends are not in doubt.

TABLE 2.5. Sources of Health Insurance, 1990 and 1997, Children Ages 18 and Younger

(Number of Children)	1990	1997
Private insurance	49,063,000	50,556,000
Medicaid	12,420,000	14,652,000
Uninsured	9,126,000	11,586,000
Total	68,619,000	75,491,000

Note: Estimated from the Current Population Survey. Some children have more than one kind of insurance.

Figure 2.5. Sources of Children's Health Insurance, 1990 and 1997



Source: Estimated from the Current Population Survey. Some children have more than one kind of insurance.

Figure 2.6.
Uninsured Children by Age, 1997

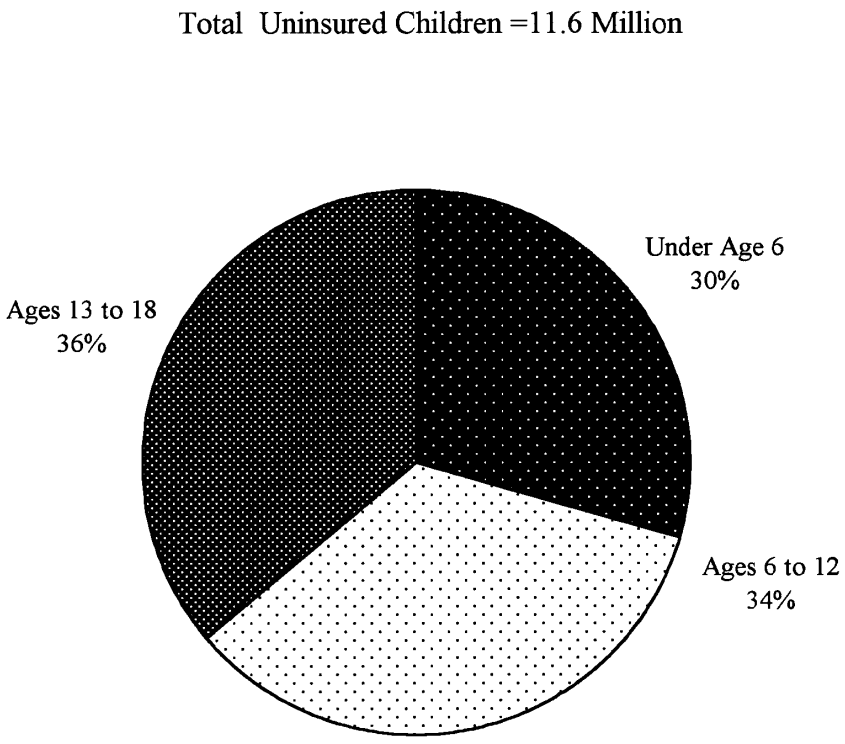
Figure 2.6 shows the distribution of uninsured children ages 18 and younger by age. The 11.6 million children without health insurance in 1997 comprised 15.4% of all children under age 19. Of this number, 29.6% were under age 6, 34.2% were ages 6 to 12, and 36.2% were ages 13 to 18. Among the three age groups, the highest proportion of uninsured children was among those 13 to 18 years old, 17.9% of whom were uninsured. The lowest rate of uninsured children was among those 6 to 12 years old, 14.1% of whom were without health insurance in 1997.

TABLE 2.6. Uninsured Children by Age, 1997

	Number	Percent
Under age 6	3,424,000	29.6
Ages 6–12	3,968,000	34.2
Ages 13–18	4,195,000	36.2
Total	11,586,000	100.0

Note: Estimated from the Current Population Survey.

Figure 2.6. Uninsured Children by Age, 1997



Source: Estimated from the Current Population Survey, March 1998.

Figure 2.7.
Uninsured Children by Family's Income Relative to Poverty Thresholds, 1997

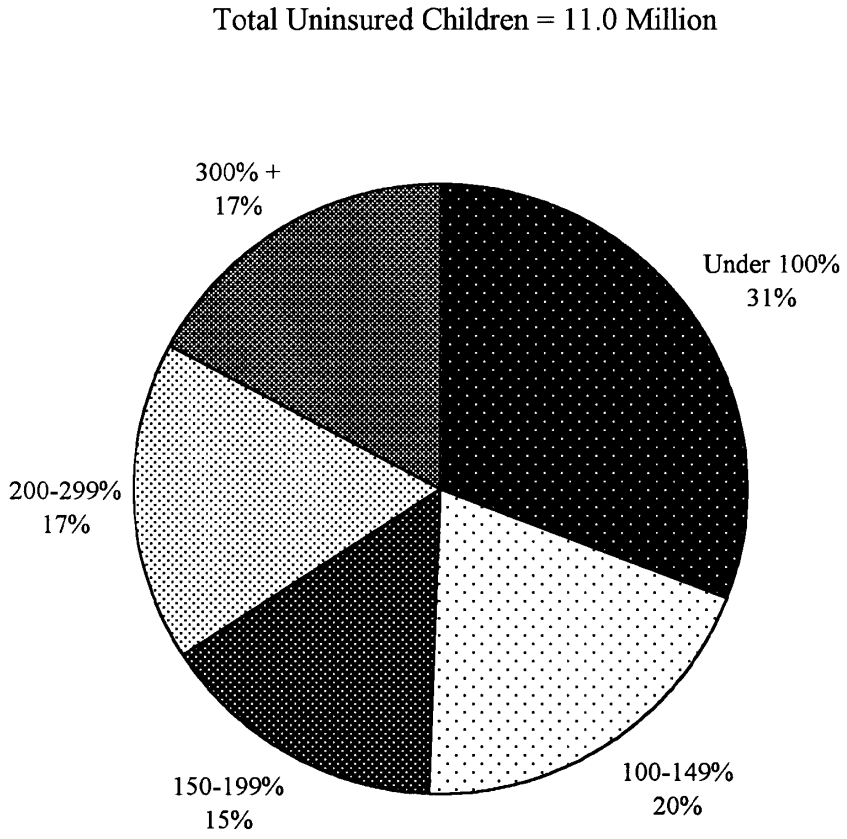
Figure 2.7 displays the distribution of uninsured children by their family income relative to the federal poverty thresholds. Almost one-third of uninsured children were in families with income below the poverty line in 1997. Slightly more than one-third of children without health insurance were in families with incomes between 100% and 200% of the poverty level. About 17% of uninsured children were in families with incomes equal to three times the poverty level or higher. This analysis only includes children living with family members.

TABLE 2.7. Uninsured Children by Family's Income Relative to Poverty Thresholds, 1997

	Number	Percent
Under 100%	3,396,000	30.8
100%–149%	2,182,000	19.8
150%–199%	1,680,000	15.3
200%–299%	1,846,000	16.8
300%+	1,912,000	17.3
Total	11,016,000	100.0

Note: Estimated from the Current Population Survey. Excludes children not in families. Does not include 571,000 uninsured children who lived with non-relatives.

Figure 2.7. Uninsured Children by Family's Income Relative to Poverty Thresholds, 1997



Source: Estimated from the Current Population Survey, March 1998.

Figure 2.8.
Uninsured Children by Parents' Insurance Status, 1997

Figure 2.8 reports the health insurance status of the head of the family in which there was a child without health insurance in 1997. Only 17.1% of these children lived with a family head who had employment-based group coverage. Most uninsured children—80.4%—were members of families in which both parents or the only parent present in the household also were uninsured.

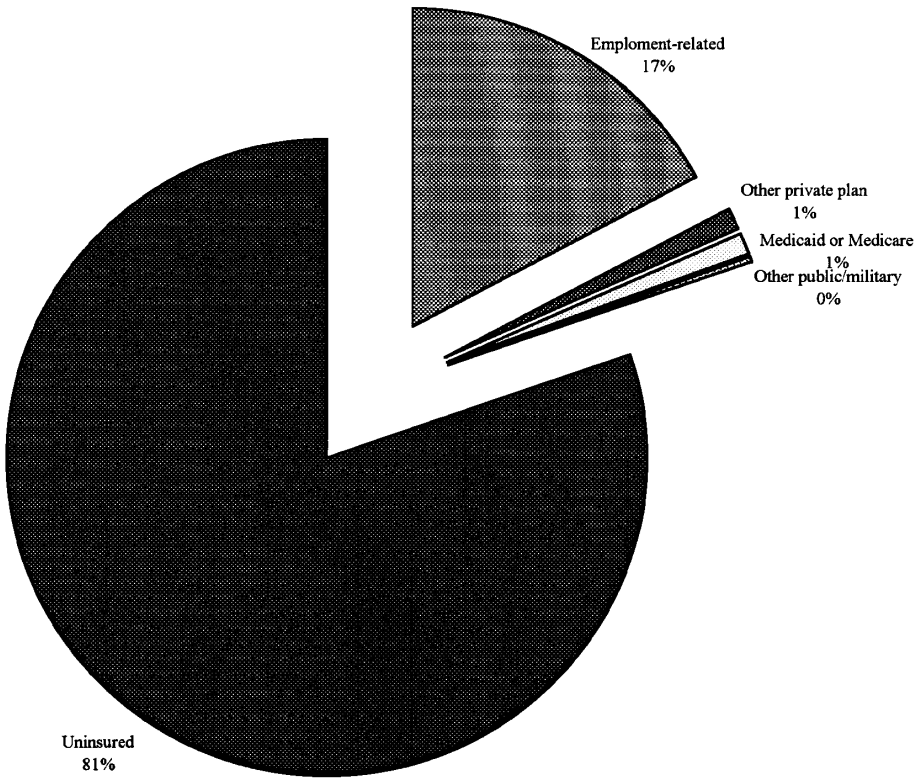
TABLE 2.8. Uninsured Children by Parents' Insurance Status, 1997

	Number	Percent
Employment-related	1,888,000	17.1
Other private plan	123,000	1.1
Medicare or Medicaid	131,000	1.2
Other public	19,000	0.2
Uninsured	8,855,000	80.4
Total	11,016,000	100.0

Note: Estimated from the Current Population Survey. Does not include 571,000 uninsured children who lived with non-relatives.

Figure 2.8. Uninsured Children by Parents' Insurance Status, 1997

Total Uninsured Children = 11.0 million



Source: Estimated from the Current Population Survey. Excludes 571,000 uninsured children who lived with non-relatives.

Figure 2.9.
Uninsured Children by Parents' Employment Status, 1997

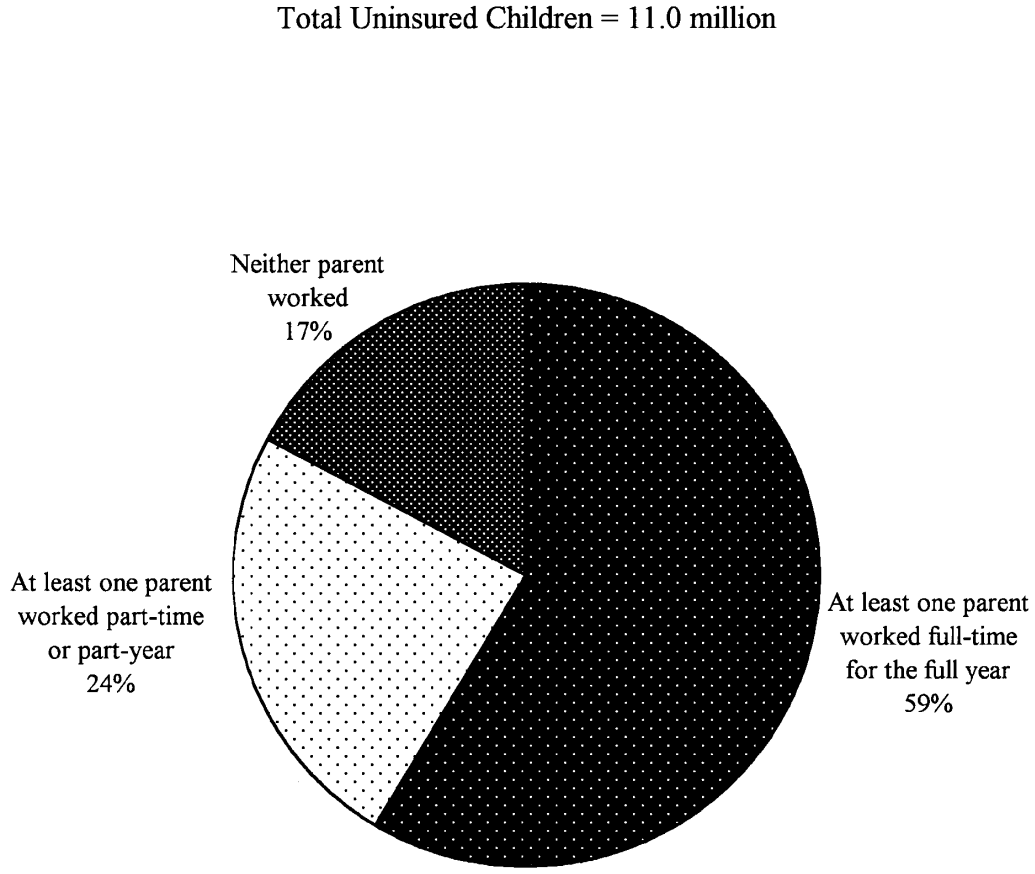
Figure 2.9 describes the employment status of the parent(s) of uninsured children. In 1997, almost 59% of uninsured children had at least one parent who worked full-time for the full year. Only 17% of children without health insurance were in families in which there was not at least one working parent.

TABLE 2.9. Uninsured Children by Parents' Employment Status, 1997

	Number	Percent
At least one parent worked full-time for the full year	6,447,000	58.5
At least one parent worked part-time or part-year	2,664,000	24.2
Neither parent worked	1,905,000	17.3
Total	11,016,000	100.0

Note: Estimated from the Current Population Survey. Does not include 571,000 uninsured children who lived with non-relatives.

Figure 2.9. Uninsured Children by Parents' Employment Status, 1997



Source: Estimated from the Current Population Survey. Excludes 571,000 uninsured children who lived with non-relatives.

Figure 2.10.
Uninsured Children by Size of Largest Firm Employing Either Parent, 1997

Figure 2.10 shows the number of workers at the largest firm that employed either parent of a child without health insurance.[1] About 38% of these children lived in families in which neither parent worked for a firm with more than 25 employees. Nearly 27% of uninsured children lived in families in which neither parent worked for a firm with 10 or more employees. Only 19% of uninsured children were in families in which a parent was employed by a firm with 1,000 or more workers.

TABLE 2.10. Uninsured Children by Size of Largest Firm Employing Either Parent, 1997

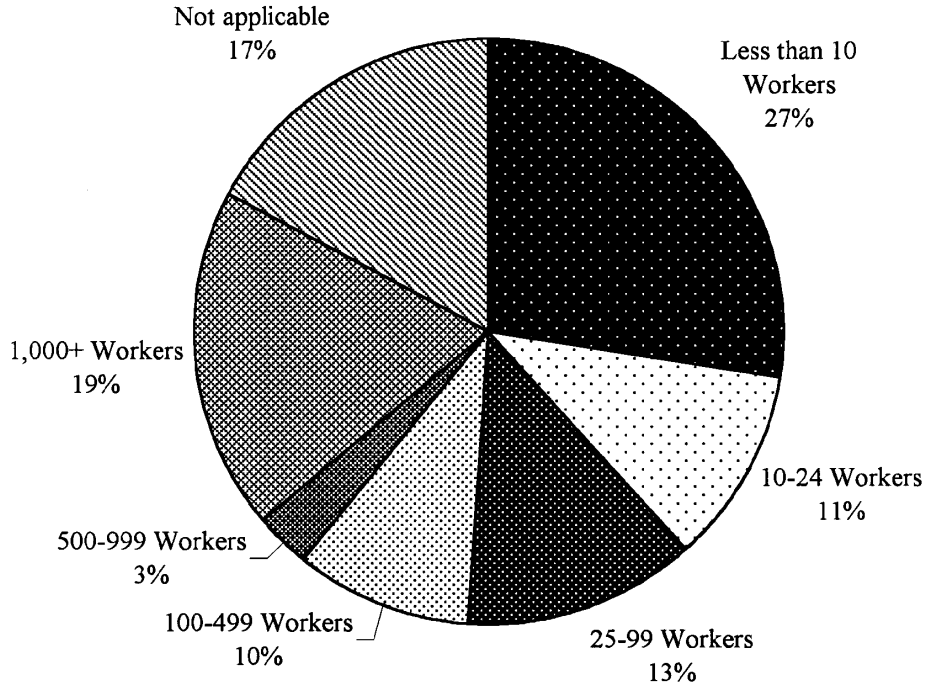
	Number	Percent
<10 Workers	3,015,000	27.4
10–24 Workers	1,217,000	11.0
25–99 Workers	1,384,000	12.5
100–499 Workers	1,080,000	9.8
500–999 Workers	331,000	3.0
1,000+ Workers	2,083,000	19.0
Not applicable	1,905,000	17.3
Total	11,016,000	100.0

Note: Estimated from the Current Population Survey. Does not include 571,000 uninsured children who lived with non-relatives.

[1] The firm comprises all locations at which the employer does business including, but not limited to, the establishment where the head of the family participating in this survey went to work each day.

Figure 2.10. Uninsured Children by Size of Largest Firm Employing Either Parent, 1997

Total Uninsured Children = 11.0 million



Source: Estimated from the Current Population Survey, March 1998. Excludes 571,000 uninsured children who lived with non-relatives.

Figure 2.11.
Enrollment in Employment-Based Health Plans, by Plan Type, 1988–1998

Health plan enrollments shifted dramatically from 1988 to 1998. Among employees of private and public employers with more than 200 workers, enrollment in conventional fee-for-service (FFS) plans declined from 71% of the total to 14%. Enrollees shifted from FFS plans to health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans. (POS plans resemble an HMO for in-network services, and a FFS plan for out-of-network care.)

The shift to managed care was rapid. In 1988, almost three quarters (71%) of enrollees were in conventional FFS plans, and the remaining 29% were in some form of managed care, either an HMO or PPO plan. Four years later, in 1992, slightly less than half (45%) were in FFS plans. By 1998, only 14% of enrollees were in FFS plans, and 86% were enrolled in managed care plans.

TABLE 2.11. Enrollment in Employment-Based Health Plans, by Plan Type, 1988–1998

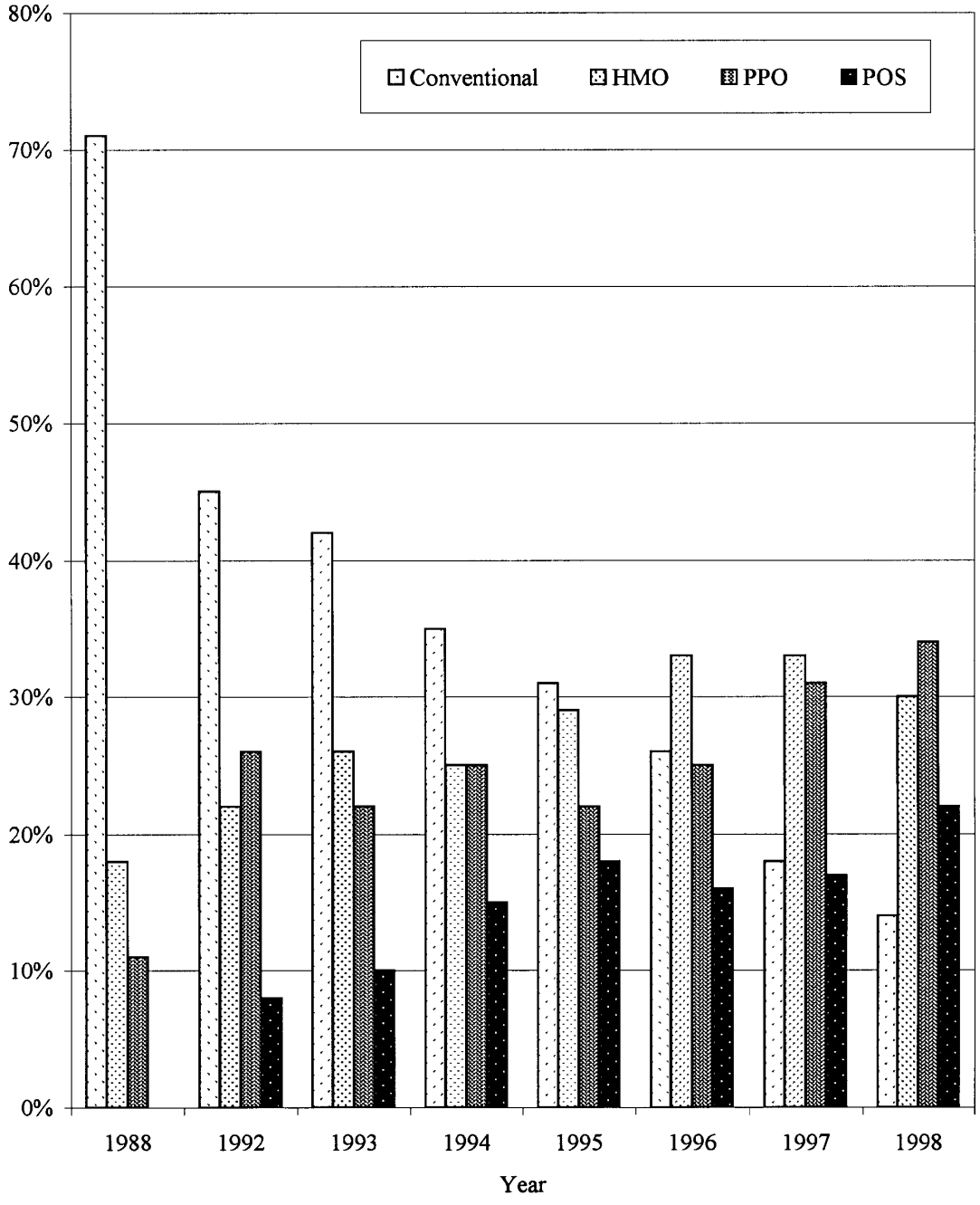
(in percent)

Year	Type of Plan			
	Conventional	HMO	PPO	POS
1988	71	18	11	0
1992	45	22	26	8
1993	42	26	22	10
1994	35	25	25	15
1995	31	29	22	18
1996	26	33	25	16
1997	18	33	31	17
1998	14	30	34	22

Note: Table prepared by CRS.

Source: KPMG Health Benefits in 1998, figure 36, p. 40.

Figure 2.11. Enrollment in Employment-Based Health Plans, by Plan Type 1988-1998



Source: Chart prepared by CRS based on KPMG, Health Benefits in 1998, figure 36, p. 40

Figure 2.12.
Change in Employment-Based Health Insurance Premiums, 1995–1998

Health insurance premiums increased more rapidly in 1998 than in recent years, about 2% to 3% overall, according to surveys of employers by the HayGroup and KPMG. Premium increases exceeding 10% annually in the early 1990s were followed by more modest increases and declines, or almost zero growth, in 1996. Since 1997, premiums have increased moderately, in general.

HMO plans saw the lowest premium growth over the 1995–1998 period, increasing about 1%. Premiums in POS, PPOs and FFS grew between 2% and 3%. (The higher growth in FFS and PPO plans premiums may help explain the decline in FFS and PPO enrollment over this period; similarly, the lower premium growth in HMO plans probably encouraged greater enrollment in these types of plans.)

TABLE 2.12. Change in Employment-Based Health Insurance Premiums, 1995–1998

(in percent)

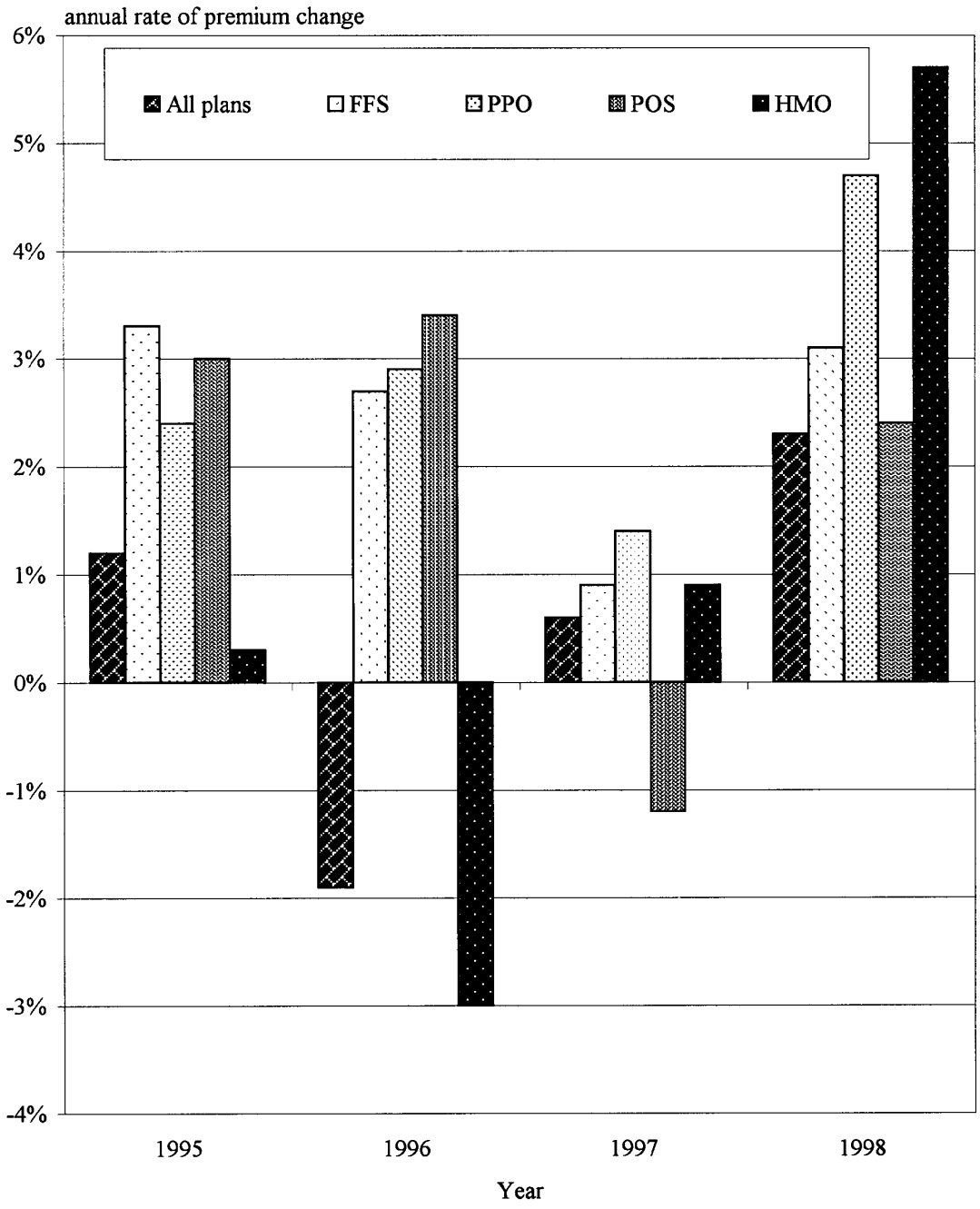
Year	All Plans	FFS	HMO	PPO	POS
HayGroup Survey					
1991	12.9	*	*	*	*
1992	11.5	*	*	*	*
1993	8.3	*	*	*	*
1994	2.7	*	*	*	*
1995	1.2	3.3	0.3	2.4	3.0
1996	−1.9	2.7	−3.0	2.9	3.4
1997	0.6	0.9	0.9	1.4	−1.2
1998	2.3	3.1	5.7	4.7	2.4
1995–1998, annual average	0.6	2.5	1.0	2.9	1.9
KPMG Survey					
1991	11.5	12.0	12.1	10.1	0.0
1992	10.9	11.0	9.8	10.6	12.4
1993	8.0	8.5	8.3	8.2	4.9
1994	4.8	5.1	5.3	3.2	5.9
1995	2.1	2.7	0.4	3.5	2.4
1996	0.5	1.2	−0.4	0.6	1.2
1997	2.1	2.6	2.0	2.1	1.9
1998	3.3	3.5	2.9	3.8	2.9
1995–1998, annual average	2.0	2.5	1.2	2.5	2.1

*Not available.

Notes: Table prepared by CRS. FFS is fee-for-service; HMO is health maintenance organization; PPO is preferred provider organization; and POS is point-of-service.

Sources: HayGroup, Hay Benefits Report trend data, 1999 and KPMG, Health Benefits in 1998, figure 2, p. 7.

Figure 2.12. Change in Employment-Based Health Insurance Premiums, 1995-1998

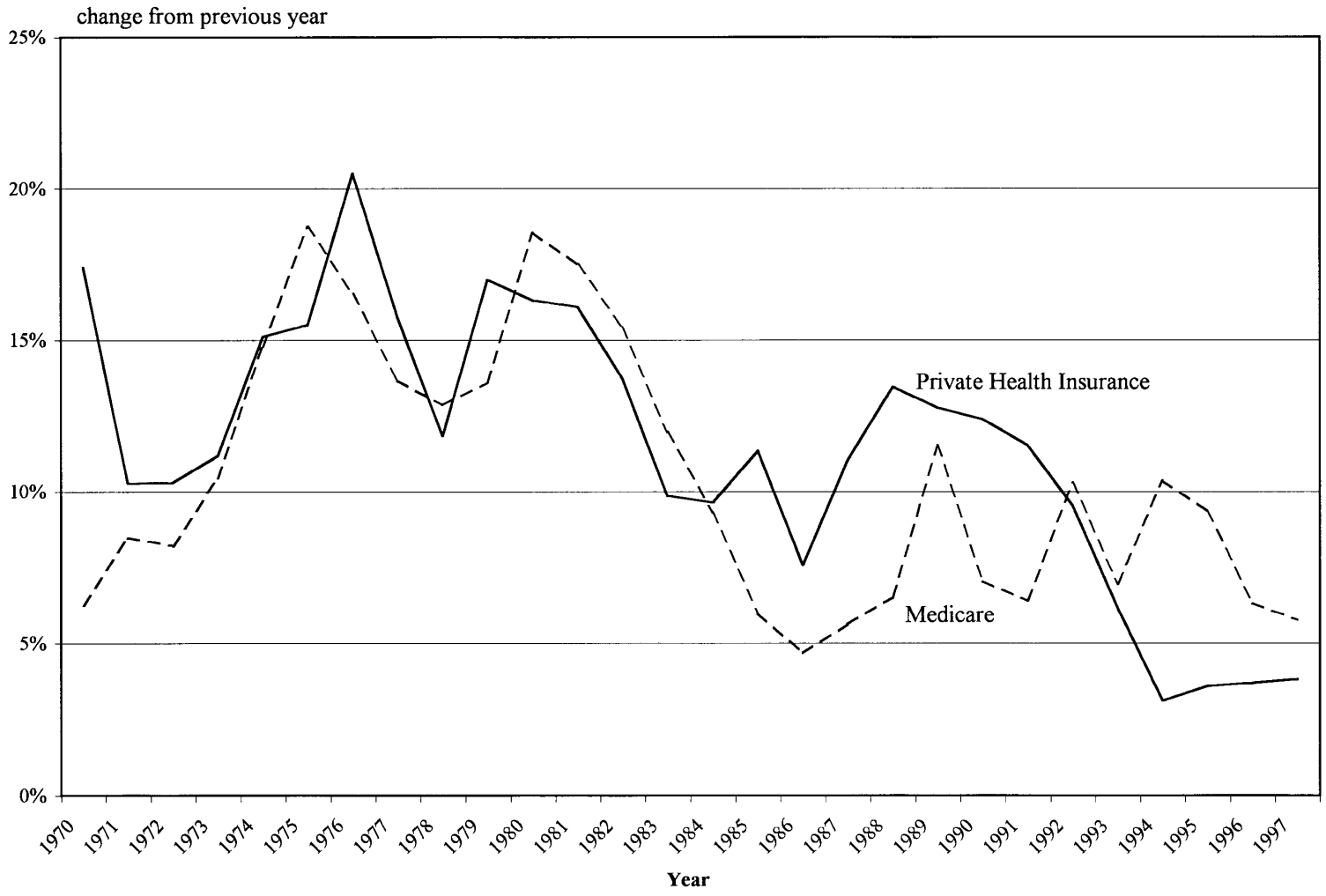


Source: Figure prepared by CRS based on data obtained from the HayGroup.

Figure 2.13.
Comparison of Growth in Medicare and Private Health Insurance, 1970–1997

Over the past 27 years, Medicare and private health insurance (PHI) spending per enrollee have grown at comparable rates: 10.4% annually under Medicare and 11.4% annually under PHI. This overall similarity masks significant differences between growth for the two sources during 2 periods, however. From 1985 to 1991, the rate of growth in PHI spending per enrollee far outpaced the rate of growth in Medicare spending per enrollee, with PHI averaging 11.4% annual increases compared to 6.9% for Medicare. From 1993 to 1996, growth in Medicare spending per enrollee (8.7% annually) exceeded growth in PHI per enrollee (3.5% annually). Since 1996, Medicare growth has moderated and PHI growth has increased, resulting in a narrowing of the gap between growth rates.

Figure 2.13. Comparison of Growth in Medicare and Private Health Insurance, 1970-1997



Source: Figure prepared by CRS based on data from the Health Care Financing Administration (HCFA).

Figure 2.14.
Distribution of HMOs by Plan Type, 1997

Increasing numbers of employees and their families are enrolling in managed care plans, including HMOs, PPOs, and other types of managed care delivery system arrangements. There are different types of HMOs. Staff and group model HMOs were the earliest managed care plans. In a staff model HMO, physicians are salaried employees who, typically, provide care in HMO-owned offices and hospitals. A group model HMO contracts with one or more multispecialty medical groups to provide all covered services to HMO participants in exchange for a per capita fee. Each medical group's practice is limited, largely, to the HMO membership and it is managed independently of the HMO. Physicians contract with the medical group, which may compensate them on a risk-sharing, cost, or salary basis.

A newer variant is the individual or independent practice association, or IPA model. An IPA contracts directly with physicians in independent practice, associations of physicians in independent practices, or multispecialty group practices. Participating physicians retain their private practices, in their own offices, but they see HMO patients as part of that practice. Typically, IPA physicians do not have an exclusive relationship with a single HMO.

A network or mixed model HMO can offer the broadest provider participation of any type of HMO because it contracts with staff, group and IPA models in combination. Network model HMOs may contract with primary and specialty care provider groups as well as hospitals—a practice which helps spread financial risk. Network model HMOs offer the least amount of control or management of providers' utilization of services and resources. Moreover, providers typically do not have exclusive contracting relationships with network HMOs.

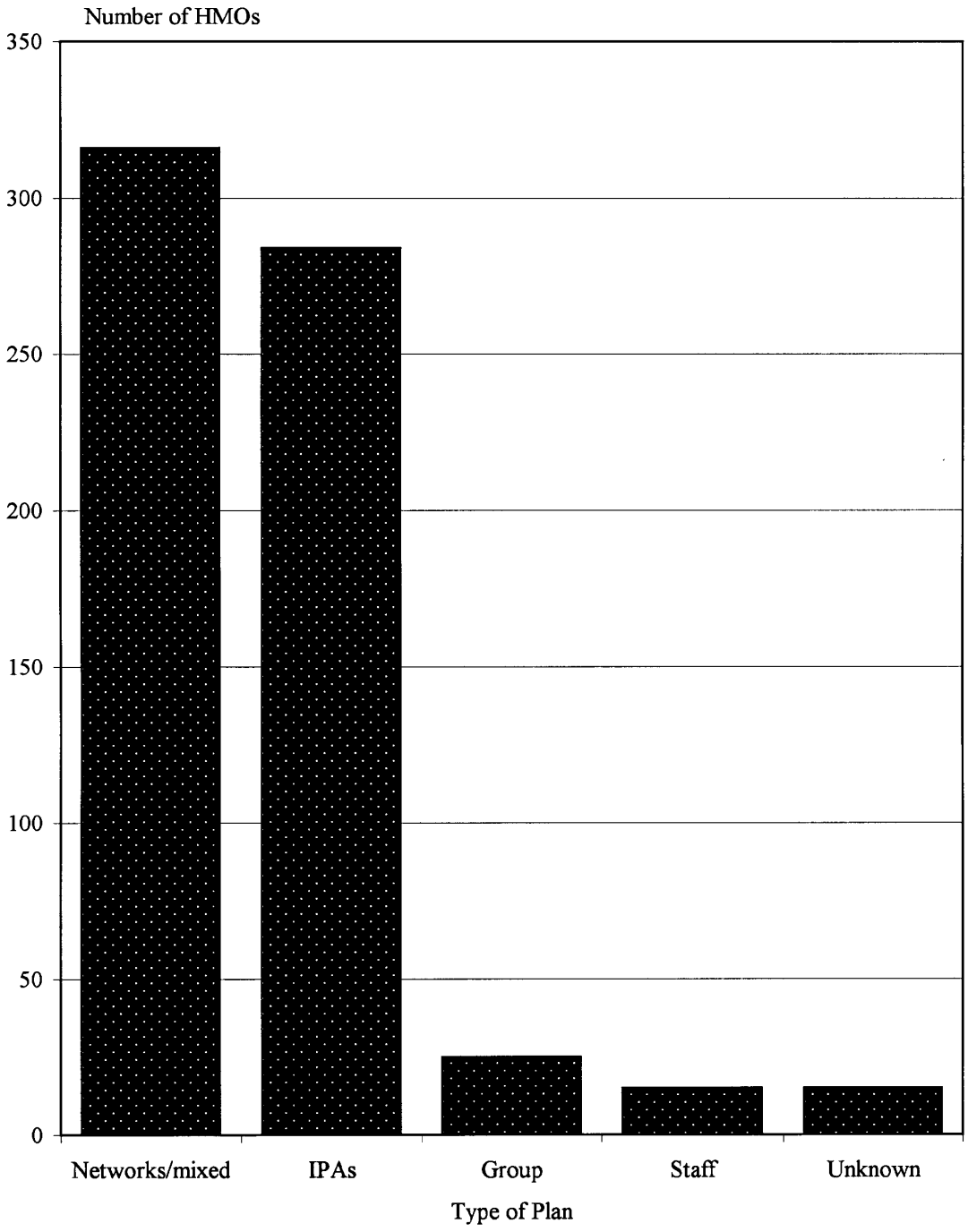
In January, 1997 there were 651 HMOs nationwide. Most HMOs were mixed model HMOs (49%) or IPAs (44%).

TABLE 2.14. Distribution of HMOs by Plan Type, 1997

	Number	Percent
Network/mixed	316	49
IPAs	284	44
Group	25	4
Staff	15	2
Unknown	15	2

Source: American Association of Health Plans, Managed Care Facts, January 1998.

Figure 2.14. Distribution of HMOs by Plan Type, 1997



Source: Figure prepared by CRS based on AAHP, *Managed Care Facts,* January 1998.

Figure 2.15.
HMO Enrollment, 1990–1996

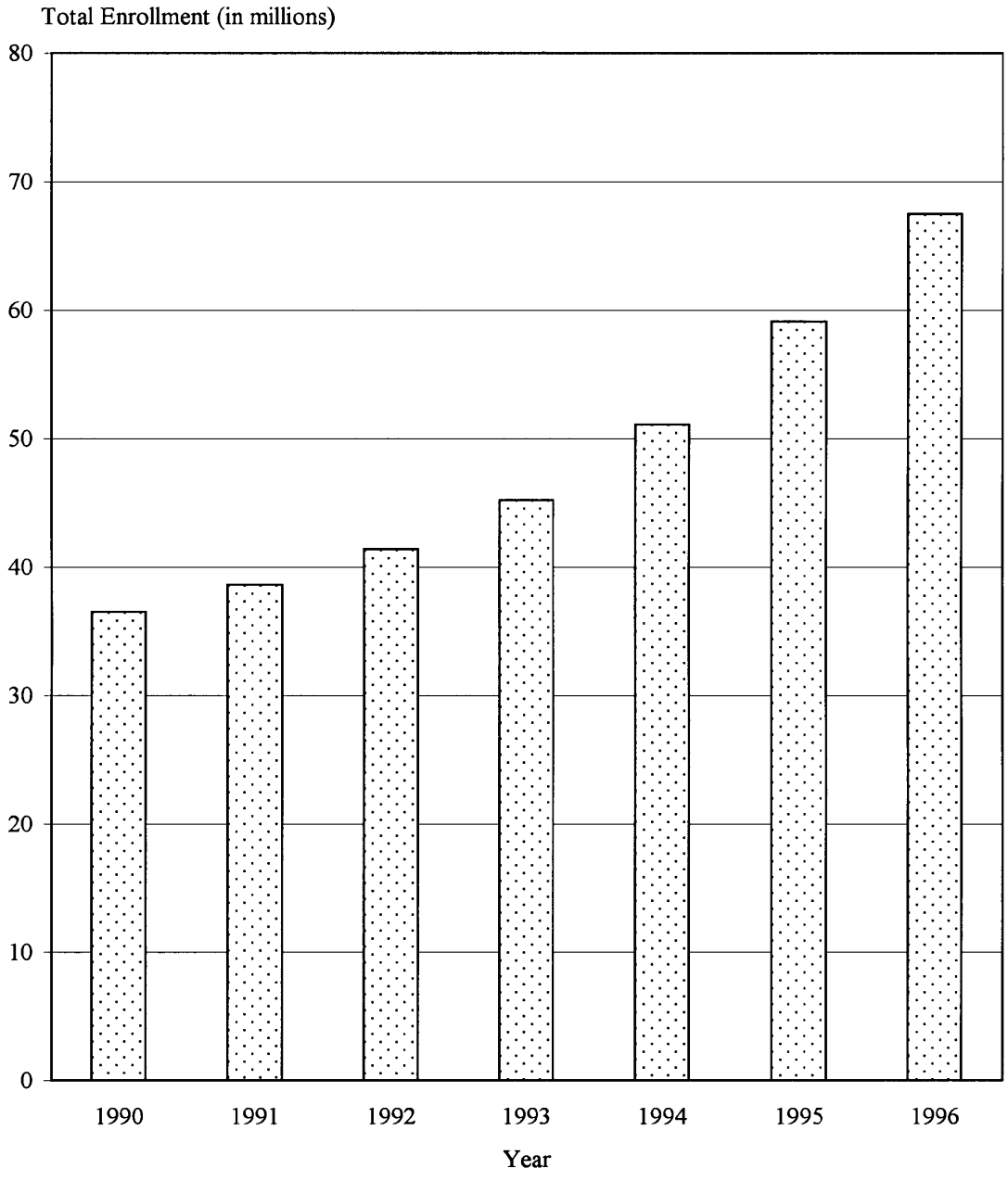
In 1996, about 67.5 million people, or about 1 in 4 Americans, were enrolled in an HMO. Since 1990, HMO enrollment has increased by 85%.

TABLE 2.15. HMO Enrollment, 1990–1996

Year	Total Enrollment (in millions)
1990	36.5
1991	38.6
1992	41.4
1993	45.2
1994	51.1
1995	59.1
1996	67.5

Note: Table prepared by the CRS based on data in American Association of Health Plans, Managed Care Facts, January 1998.

Figure 2.15. HMO Enrollment, 1990-1996



Source: Figure prepared by CRS based on AAHP, *Managed Care Facts,* January 1998.

Figure 2.16.
Preferred Provider Organization (PPO) Enrollment, 1990–1996

A PPO is a health plan arrangement in which providers contract to provide services to enrollees for discounted amounts, usually paid on a fee-for-service (FFS) basis. Enrollees in the PPO may use other non-preferred providers, usually with higher coinsurance requirements. One way the typical PPO differs from HMOs is that visits to specialists generally do not require referral by an enrollee's primary care provider.

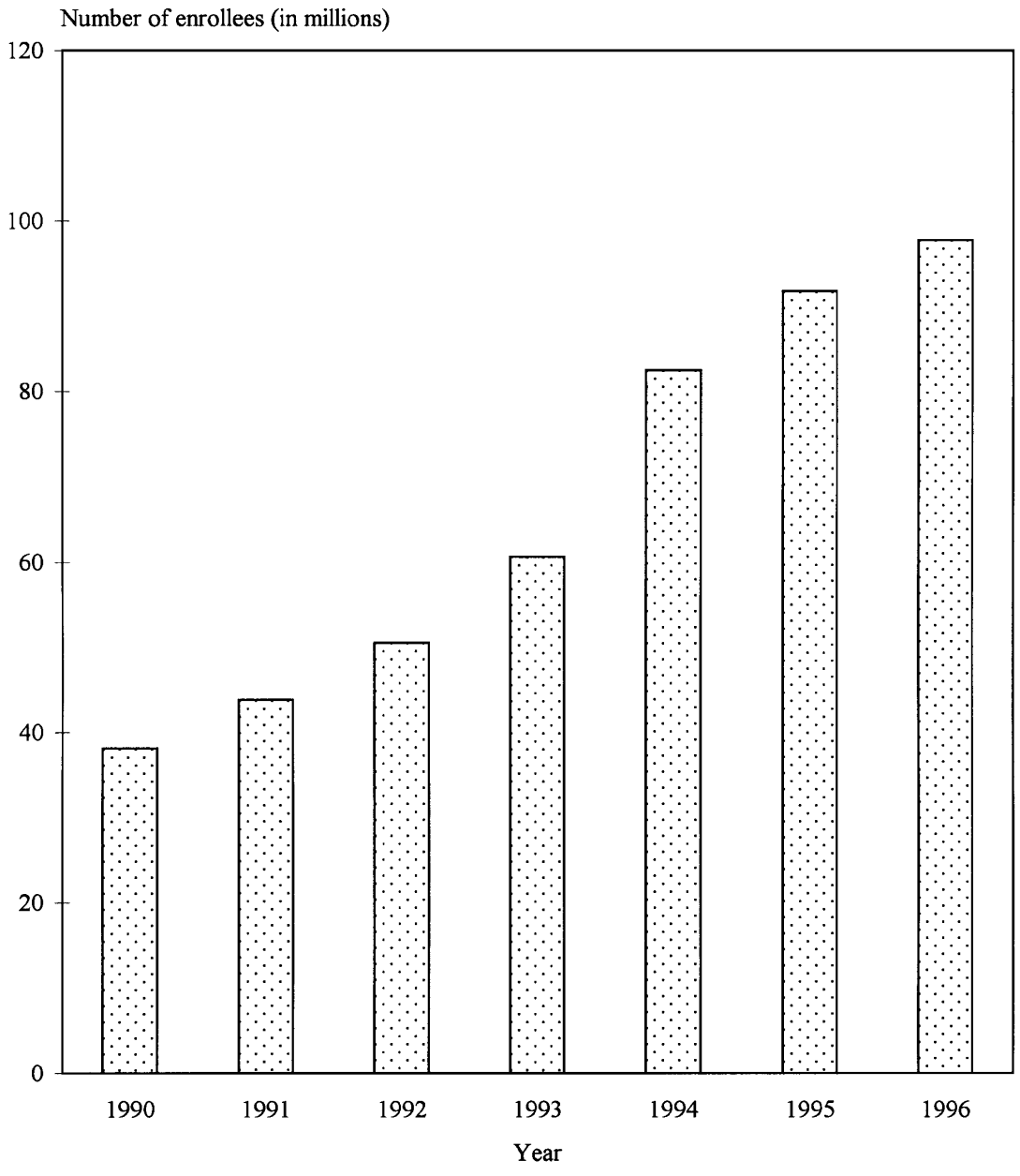
Enrollment in PPOs has been rising, increasing over 150% between 1990 and 1996.

TABLE 2.16. PPO Enrollment, 1990–1996

Year	Total Enrollment (in millions)
1990	38.1
1991	43.8
1992	50.5
1993	60.6
1994	82.5
1995	91.8
1996	97.8

Note: Table prepared by CRS based on data from American Association of Health Plans, Managed Care Facts, January 1998.

Figure 2.16. Preferred Provider Organization (PPO) Enrollment, 1990-1996



Source: Figure prepared by CRS based on AAHP, *Managed Care Facts,* January 1998.

Figure 2.17.
Provider Incentives and Capitation Contracts

Managed care organizations use a variety of physician incentive plans to compensate physicians, some of which share financial risk with the providers. Capitation, which entails the payment of a fixed-fee per member per month for all covered services regardless of the level of service utilization, represents the primary method of risk-sharing. Forty-five percent (45%) of total reimbursements to primary care physicians and 48% of total reimbursements to specialists were through capitation. Almost half (48%) of HMOs used per diem costs to reimburse both inpatient and ambulatory hospital services.[2]

Nearly two-thirds of providers indicated that their contracts include financial incentives or disincentives above the base capitation rate. Primary care and multispecialty groups were the most likely to have financial incentives, while specialists and hospitals were the least likely.[3] For providers reporting receiving an incentive, the incentive represented about 6% of total compensation, on average, with higher percentages among providers in PHOs and hospitals, and lower percentages among providers in multispecialty groups/IPAs. Utilization influences incentives/disincentives for providers in multispecialty groups/independent practice associations (IPAs), primary care groups and specialists, while costs were reported as significant factors among providers in physician-hospital organizations (PHOs).

TABLE 2.17. Incentives/Disincentives Beyond the Capitation Rate

	Contracts w/Incentives	Incentive Percent*	Factors Influencing Incentives/Disincentives				
			Utilization	Patient Satisfaction	Costs	Quality/ Outcomes	Other
Multispecialty Groups/IPAs	73%	3.3%	70%	30%	30%	20%	20%
Primary Care Groups	83%	6.1%	80%	20%	40%	40%	0%
PHOs/IDSs	63%	12.0%	40%	40%	80%	20%	0%
Specialists	50%	5.7%	58%	8%	33%	0%	0%
Hospitals	25%	9.0%	N/A	N/A	N/A	N/A	N/A
Total	61%	6.1%	63%	22%	41%	16%	6%

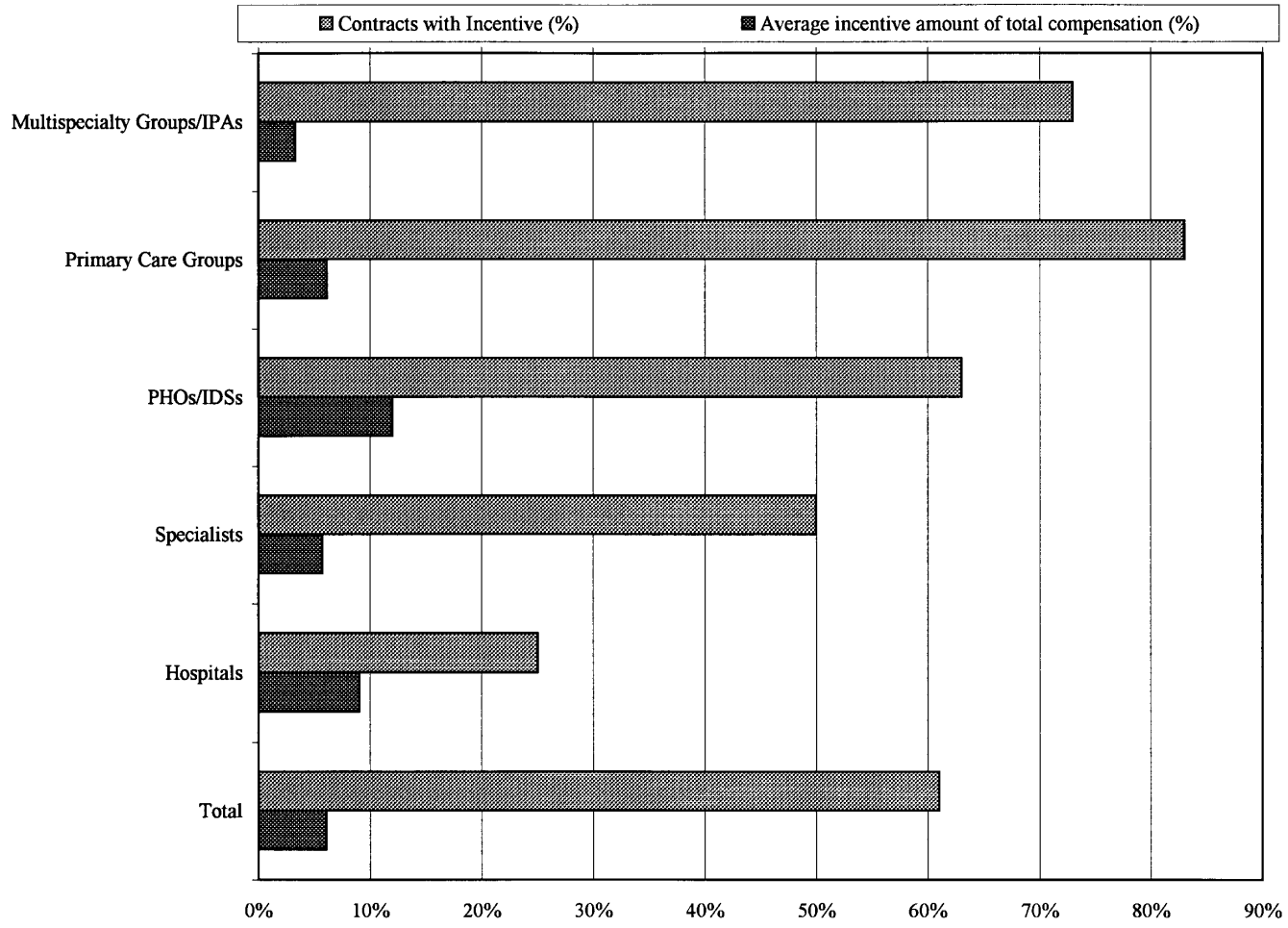
Note: Table prepared by CRS based on data from Capitation Management Report, 1997 Capitation Survey. Each provider can have more than one type of Incentive.

*Average incentive amount as a percentage of total compensation.

[2] Health Insurance Association of America, Source Book of Health Insurance Data 1997–1998, p. 54–55.

[3] Capitation Management Report, 1997 Capitation Survey.

Figure 2.17. Provider Incentives



Source: Capitation Management Report, *1997 Capitation Survey*

Figure 2.18.
State Laws Regulating Managed Care

Numerous bills are pending in the 106th Congress to establish federal standards for managed health care and other forms of health insurance. Under current law, the regulation of managed health care depends on who sponsors the plan and who bears the risk for paying for insured services. In general, the federal government regulates private sector employer health plans, including managed care plans that are sponsored by a private employer. The states regulate the business of insurance, which includes a health maintenance organization (HMO) or other type of managed care organization that sells a health insurance policy to an individual, employer, or other purchaser. States also oversee plans sponsored by state and local governments.

The states have enacted numerous laws over the last few years to expand their regulation of health insurance, and especially managed care. Figure 2.23 provides information on a subset of these laws, indicating how many states have adopted them. The description of the laws is provided by the Blue Cross and Blue Shield Association.

Any Willing Provider: Laws that compel health plans to admit to their networks any provider willing to abide by the terms and conditions of the contract. It only applies to pharmacies, except in 5 states where the scope includes most providers (ID, IN, KY, VA, WY).

Direct Access to Specialists: Laws that allow subscribers to go directly to a specialist without prior referral from the health plan's primary care physician. The laws apply primarily to obstetricians-gynecologists, but also can refer to chiropractors, dermatologists, etc.

Patient Disclosure/"Gag Clause": Laws that ban health plans from including so-called "gag clauses" in provider contracts that prohibit or discourage a provider from discussing alternative treatment options and appropriate care with patients.

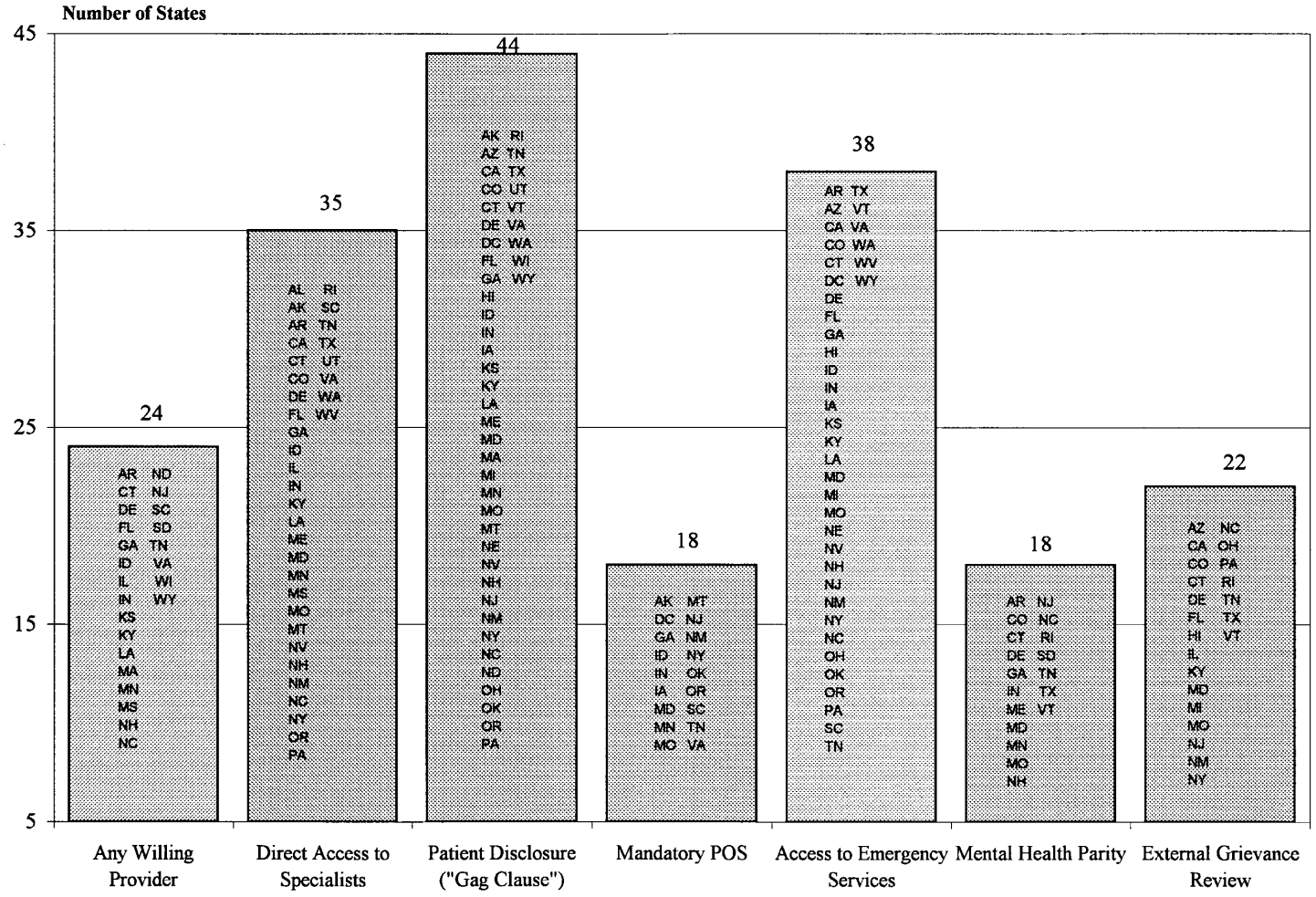
Mandatory Point-of-Service (POS): Laws that require health plans to offer a POS product to employer groups at the employer's option, in addition to a gatekeeper product like an HMO. Two states (ID and MT) impose a mandatory POS requirement (i.e., an HMO must offer POS).

Access to Emergency Services: Laws that impose new requirements to pay for certain care delivered in an emergency room. Several of the laws also impose a "prudent layperson" standard to define what constitutes a medical emergency.

Mental Health Parity: Laws that require health plans to provide equivalent benefits and cost-sharing requirements for mental and physical illnesses. These states generally have limited parity mandates that either limit the definition of mental illness, the scope of benefits, and/or allow increased cost-sharing.

External Grievance Review: Laws that require health plans to allow enrollees to appeal a coverage or claims denial to an outside medical expert panel, if dissatisfied with the outcome of the plan's internal appeals process.

Figure 2.18. State Laws Regulating Managed Care

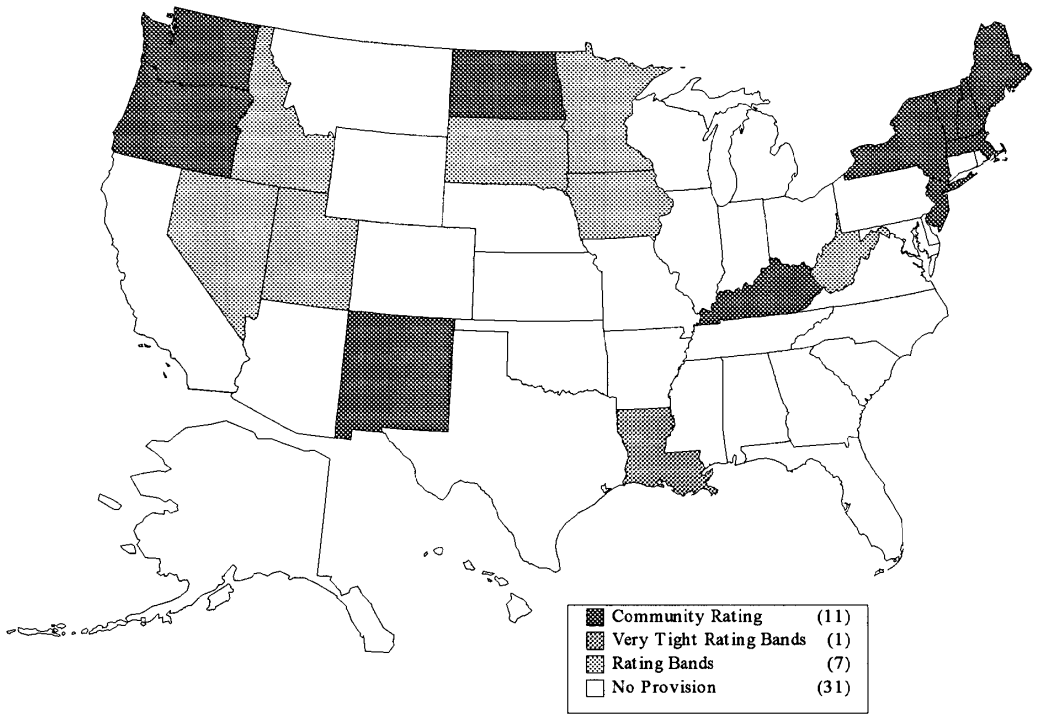


Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues*, December 1998.

Figure 2.19.
State Premium Rating Restrictions in the Individual Market

As of the end of 1998, 19 states had enacted laws to regulate the premiums of health insurance sold to individuals (as opposed to groups). In those states without premium restrictions, an insurance carrier may price the insurance at whatever rate is necessary to cover the expected claims risk of the individual policy-holder and administrative overhead. Of those states that have enacted premium restrictions, the majority have adopted community rating. In the figure, a state is categorized as having community rating if its law prohibits the health insurer from using experience, health status, or duration of coverage in setting the premium rates for individual coverage. In some states, the community rate is adjusted for demographic factors, such as age and gender. The state is categorized as having very tight rating bands (i.e., limits on the range of variation of the premium) if the law significantly limits the use of experience, health status, or duration of coverage in the setting of the premium. Finally, the state is categorized as having rating bands if it has laws that restrict to some extent the plans' use of experience, health status, or duration of coverage.

Figure 2.19. State Premium Rating Restrictions in the Individual Market



Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues*, December 1998.

Figure 2.20.
State High-Risk Health Insurance Pools

Twenty-seven states have established high risk pools to provide coverage for individuals who otherwise are unable to obtain health insurance at reasonable rates. In recent years, the combined population of the risk pools has remained about 100,000. Enrollment may grow because many states have elected under the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104–191) to use existing or newly established risk pools to provide for guaranteed portability of insurance for individuals leaving the group market.

A risk pool is generally a state-created, nonprofit association. It offers comprehensive health insurance benefits at a rate that typically costs more than standard insurance but is capped by law (usually at 125% to 150% of the standard rate charged in the individual insurance market). Each pool is expected to lose money because the premiums are set at an amount that is not expected to pay for the claims of the pool's enrollees. The states fund the losses of the pool in a variety of ways. Most assess health insurance carriers in the state on a proportional basis (e.g., as a specified percentage of their health insurance premiums). A few allocate funds from state income tax, tobacco tax, or general revenues. Still others use a combination of assessments on insurers and other funding mechanisms.

Figure 2.20. State High-Risk Health Insurance Pools

State	Year Operational	Current Enrollees	Premium Cap (in percent)*	State	Year Operational	Current Enrollees	Premium Cap (in percent)*
AL† ..	1998	690	200	MO	1992	1,032	150–200
AK	1993	198	200	MT	1987	704	150
AR	1996	588	150	NE	1986	3,997	135
CA‡ ..	1991	19.995	125–137.5	NM	1988	792	150
CO	1991	1,058	150	ND	1982	1,328	135
CT	1976	1,290	125–150	OK	1996	783	125
FL‡ ..	1983	1,095	200–250	OR	1990	4,134	125
IL‡ ...	1989	5,438	125–150	SC	1990	943	200
IN	1982	3,997	150	TX	1998	1,354	137.5–200
IA	1987	482	150	UT‡	1991	888	—
KS	1993	1,019	—	WA	1988	766	150
LA	1992	747	150–200	WI	1981	7,318	200
MN ...	1976	26,314	125	WY	1991	429	125–150
MS ...	1992	1,700	150–175	27 states	.....	Total current enrollees 89,079	.....

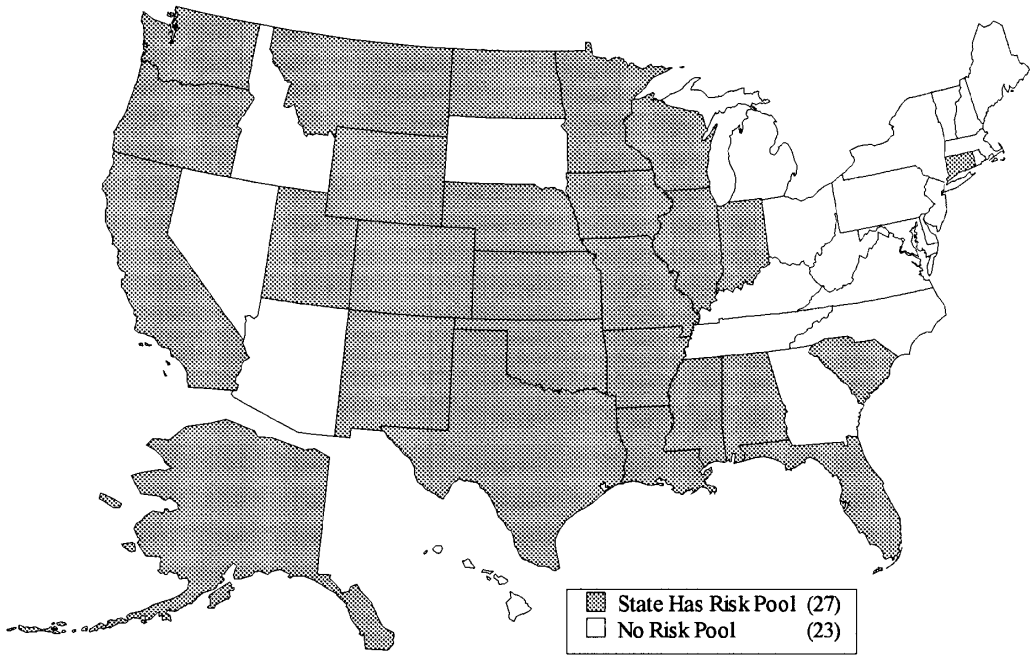
*Refers to state-imposed limits that cap premiums at no more than a fixed percentage above standard premiums charged by private heath plans for individual coverage in the state.

†Enrollment is limited to HIPAA eligibles.

‡ Periodic enrollment caps.

Note: Table prepared by CRS.

Figure 2.20. State High-Risk Health Insurance Pools



Source: Figure prepared by CRS based on Blue Cross Blue Shield Association, *State Legislative Health Care and Insurance Issues: 1998 Survey of Plans*, December 1998.

Section 3.
Medicare

Medicare is a nationwide health insurance program for the aged and certain disabled persons. The program consists of two parts: the Part A, Hospital Insurance Program and the Part B, Supplementary Medical Insurance Program.

Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. In FY1999, Part A will cover an estimated 39.0 million aged and disabled persons (including those with chronic kidney disease). Part A provides coverage for inpatient hospital services, up to 100 days of posthospital skilled nursing facility (SNF) care, home health services and hospice care. Medicare Part A is financed primarily through the hospital insurance (HI) payroll tax levied on current workers and their employers. Employers and employees each pay a tax of 1.45% on all earnings. The self-employed pay a single tax of 2.9% on earnings.

Medicare Part B is voluntary. All persons over age 65 and all persons enrolled in Part A may enroll in Part B by paying a monthly premium. In 1999, Part B will cover an estimated 36.9 million aged and disabled persons. Part B provides coverage for physicians' services, laboratory services, durable medical equipment, outpatient hospital services, some home health services, and other medical care. Part B is financed through a combination of monthly premiums levied on program beneficiaries and federal general revenues. In 1999, the premium is $45.50. Beneficiary premiums have generally represented about 25% of Part B costs. Federal general revenues (that is, tax dollars) account for the remaining 75%.

The ability of Medicare's current financing mechanism to fund program growth adequately has been of concern for many years. Prior to the enactment of the Balanced Budget Act of 1997 (BBA 97), the Part A trust fund was projected to become insolvent in 2001. In that year, revenues coming into the trust fund (primarily payroll taxes), together with any balance carried over from prior years, would have been insufficient to cover the payment for Part A benefits in that year. BBA 97 postponed the exhaustion of the trust fund until at least 2010.

While BBA 97 lowered the projected 75-year Part A deficit by one-half, the ability of the program to meet future needs continues to be a major issue. Contributing to the Part A insolvency issue are two related concerns. First, in the year 2011, the leading edge of the baby boom cohort (persons born between 1946 and 1964) turns age 65. Second, the number of workers whose payroll tax supports Part A benefits is declining. In 1997, there were 3.9 workers per beneficiary; this number is expected to be about 3.6 by 2010 and 2.3 by 2030.

Figure 3.1.
Total Medicare Outlays, FY1967–FY2009

Total Medicare spending increased significantly since the program began; however, the average annual rate of growth has slowed somewhat in recent years. Over the FY1980–FY1990 period, total outlays grew from $35.0 billion to $109.7 billion, for an average annual rate of growth of 12.1%. For the FY1990–FY1997 period, total outlays grew from $109.7 billion to $210.4 billion, for an average annual growth rate of 9.8%. Different trends are recorded for spending on Part A and Part B. The average annual rate of growth in Part A spending increased from 10.6% over the FY1980–FY1990 period to 10.9% over the FY1990–FY1997 period. Conversely, the average annual rate of growth for Part B declined from 14.9% in the FY1980–FY1990 period to 7.7% over the FY1990–FY1997 period.

BBA 97 reduced the rate of growth in Medicare spending. It also shifted some spending from Part A to Part B. The Congressional Budget Office (CBO) projects that with no further changes in law, total Medicare spending will grow from $214 billion in FY1998 to $449 billion in FY2009. This represents an average annual overall rate of growth of 7.0%. Total Part A outlays will increase at an average annual rate of growth of 5.4%, while Part B will increase at an average annual rate of growth of 9.5%.

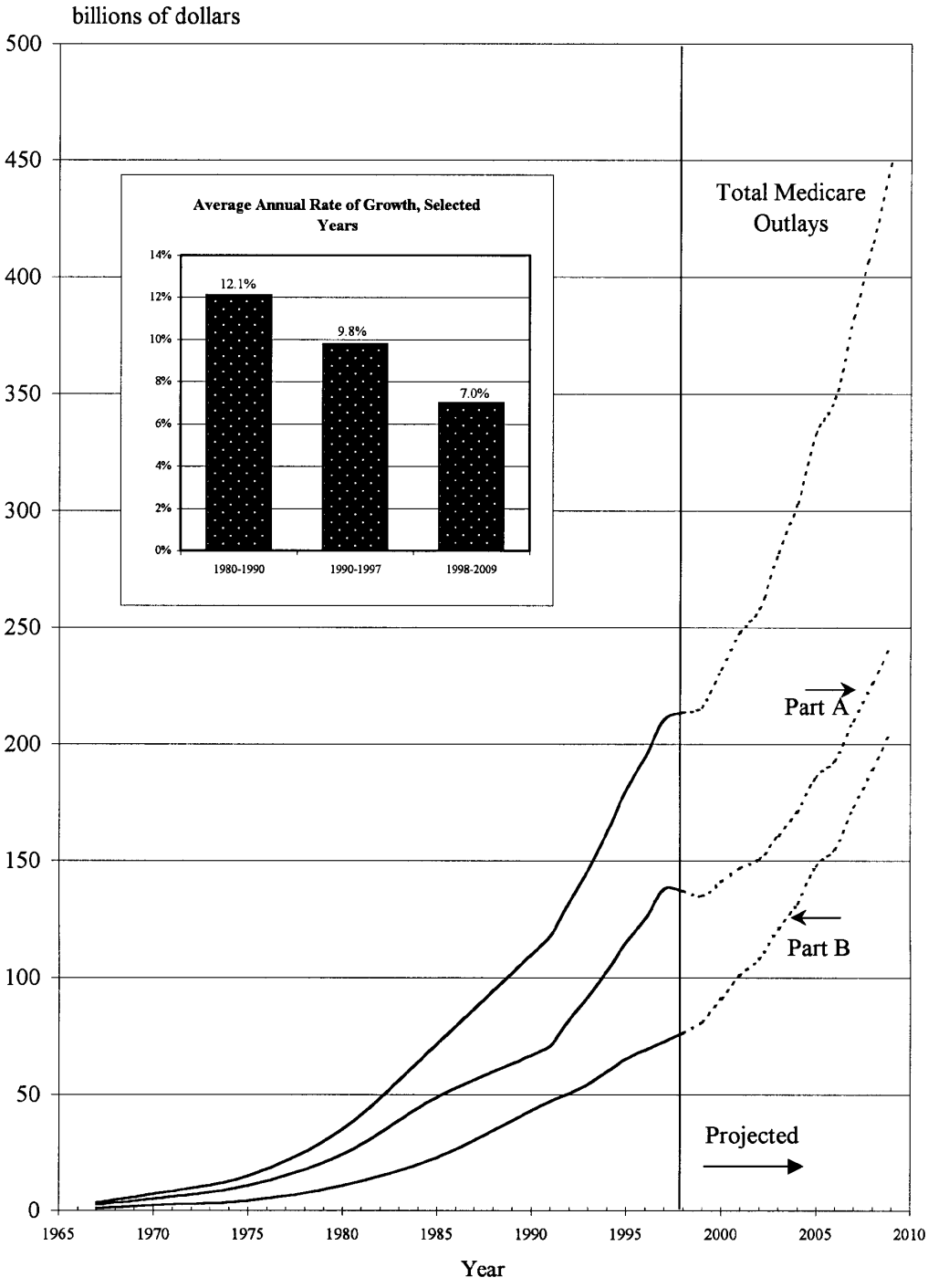
TABLE 3.1. Total Medicare Outlays, FY1967–FY2009

(in billions)

Fiscal Year	Part A	Part B	Total Medicare Outlays
1967	$2.6	$0.8	$3.4
1970	5.0	2.2	7.1
1975	10.6	4.2	14.8
1980	24.3	10.7	35.0
1985	48.7	22.7	71.4
1990	66.7	43.0	109.7
1995	114.9	65.2	180.1
1996	125.3	68.9	194.3
1997	137.9	72.5	210.4
1998	137.2	76.2	213.6
1999	135	81	216
2000	141	91	232
2001	147	101	248
2002	151	108	258
2003	161	121	282
2004	171	132	303
2005	186	148	333
2006	193	155	348
2007	210	173	383
2008	226	189	415
2009	243	206	449

Note: Data for 1999–2009 are CBO projections. Totals may not add due to rounding. Table prepared by CRS.

Figure 3.1. Total Medicare Outlays, FY1967-FY2009



Source: Figure prepared by CRS based on House Ways and Means, *1998 Green Book,* CBO baseline projections, FY1998-FY2009. (March 1999)

Figure 3.2.
Total and Net Medicare Outlays, FY1967–FY2009

Net Medicare outlays (after deduction of premiums paid by beneficiaries, primarily for Part B) have also increased significantly since the beginning of the program. The average annual rate of growth has, however, slowed in recent years. Over the FY1980–FY1990 period, the average annual rate of growth in net outlays was 11.8%; this rate declined to 9.9% for the FY1990–FY1997 period.

CBO projects that net Medicare outlays will increase from $192.8 billion in FY1998 to $395.5 billion in FY2009, for an average annual growth rate of 6.7%.

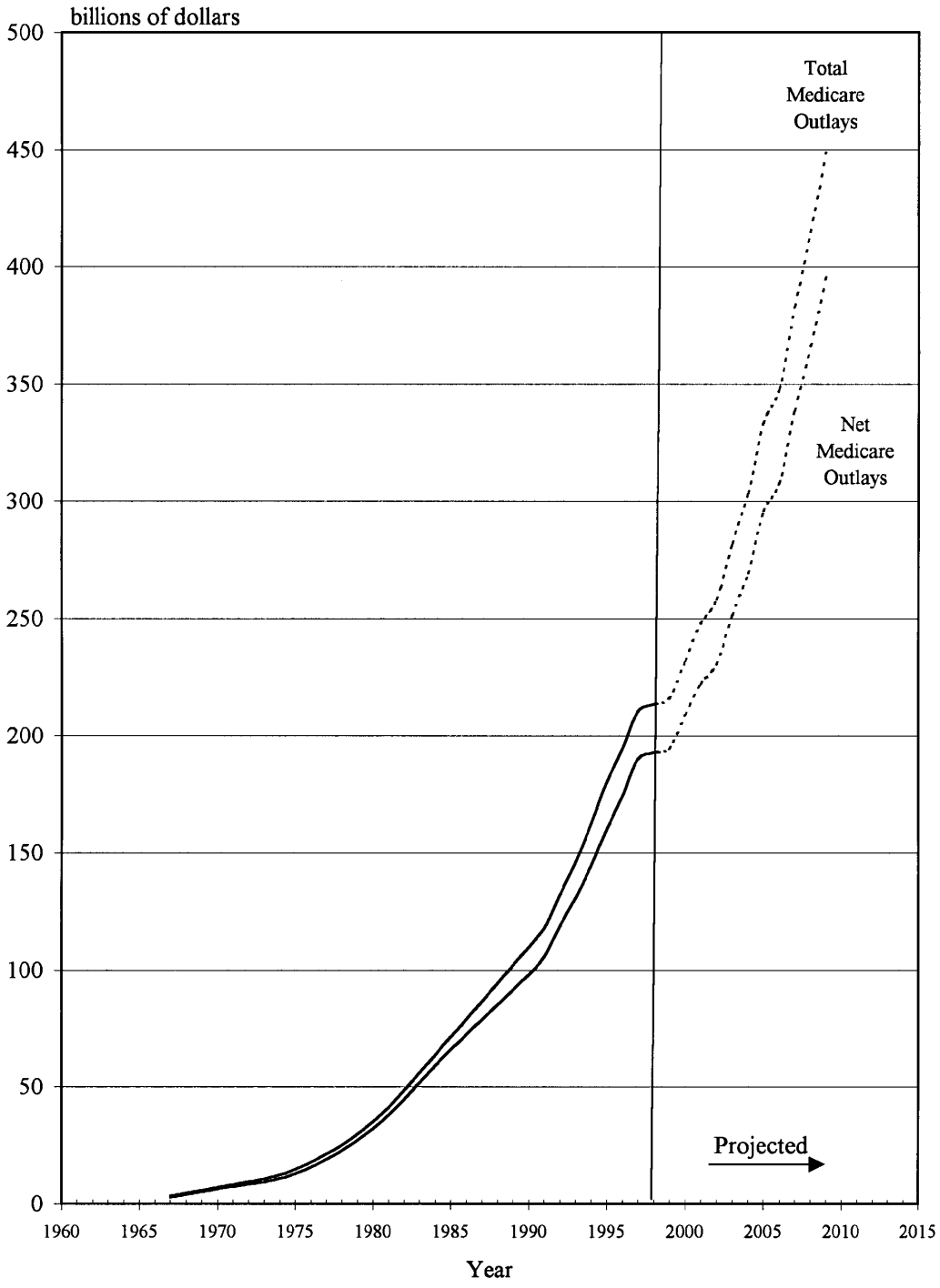
TABLE 3.2. Total and Net Medicare Outlays, FY1967–FY2009

(in billions)

Fiscal Year	Total Medicare Outlays	Medicare Premium Offset	Net Medicare Outlays
1967	$ 3.4	$–0.7	$2.7
1970	7.1	−0.9	6.2
1975	14.8	−1.9	12.9
1980	35.0	−2.9	32.1
1985	71.4	−5.6	65.8
1990	109.7	−11.6	98.1
1995	180.1	−20.2	159.9
1996	194.3	−20.1	174.2
1997	210.4	−20.4	190.0
1998	213.6	−20.8	192.8
1999	216.1	−21.5	194.6
2000	232.0	−23.2	208.8
2001	247.9	−25.4	222.4
2002	258.2	−27.7	230.5
2003	281.9	−30.6	251.3
2004	303.4	−34.1	269.3
2005	333.4	−37.6	295.8
2006	348.2	−40.4	307.7
2007	383.1	−44.4	338.7
2008	415.0	−48.7	366.3
2009	448.6	−53.1	395.5

Note: Totals may not add due to rounding. Table prepared by CRS.

Figure 3.2. Total and Net Medicare Outlays, FY1967-FY2009



Source: Figure prepared by CRS based on House Ways and Means, *1998 Green Book*, and CBO baseline projections, FY1998-FY2009.

Figure 3.3.
Total and Net Medicare Outlays in 1998 Constant Dollars, FY1967–FY1998

"Real" spending over time is measured in constant, in this case 1998, dollars. Total real Medicare spending increased significantly since the program began. Real spending more than tripled over the FY1980 to FY1997 period. Over this 18-year period, real total spending (measured in 1998 constant dollars) increased from $66.9 billion to $213.6 billion. This represents an average annual rate of growth of 6.7%. Over the same period, real net Medicare spending increased from $61.2 billion to $192.8 billion. This represents an average annual rate of increase of 6.6%. However, looking at the change between FY1997 and FY1998, there is only 0.29% for real total Medicare spending and 0.25% for real net Medicare spending.

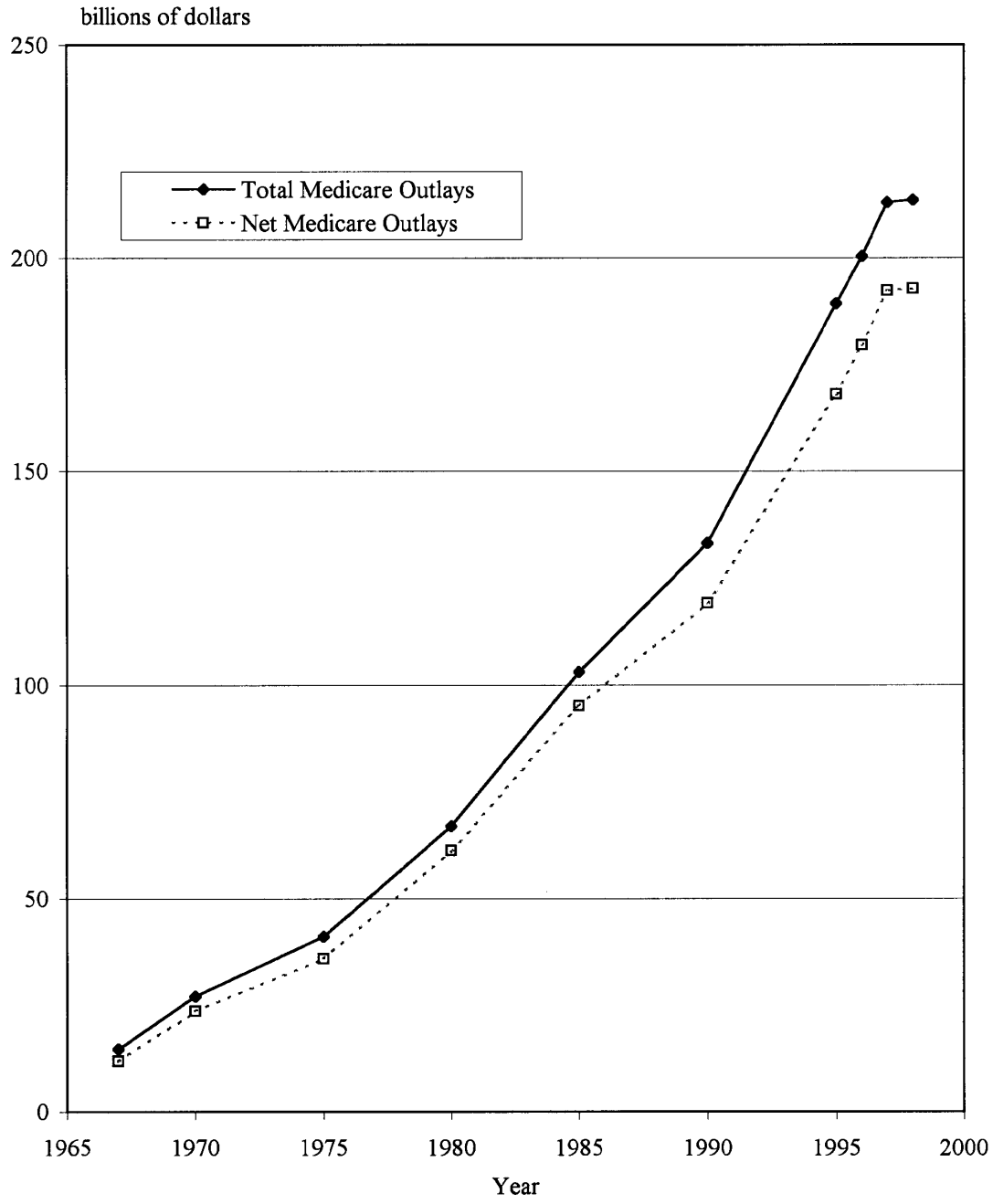
TABLE 3.3. Total and Net Medicare Outlays in 1998 Constant Dollars, FY1967–FY1998

(in billions)

Fiscal Year	Total Medicare Outlays	Medicare Premium Offset	Net Medicare Outlays
1967	$14.6	−2.8	11.8
1970	27.0	−3.5	23.5
1975	41.1	−5.3	35.8
1980	66.9	−5.6	61.2
1985	103.1	−8.0	95.1
1990	133.3	−14.1	119.2
1995	189.4	−21.3	168.1
1996	200.4	−20.7	179.6
1997	213.0	−20.6	192.3
1998	213.6	−20.8	192.8

Note: Table prepared by CRS.

Figure 3.3. Total and Net Medicare Outlays in 1998 Constant Dollars, FY1967-FY1998



Source: Figure prepared by CRS based on House Ways and Means, 1998 Green Book and CBO current baseline projections (FY97-98). Constant dollars based on chain-type price index for GDP, table 1-1, NIPA, BEA.

Figure 3.4.
Age and Gender Distribution of Medicare Beneficiaries, 1996

In 1996, approximately 38.1 million persons were enrolled in Medicare. The vast majority of enrollees—33.4 million—were aged. An additional 4.7 million, or 12.3% of the total, were disabled. Over half of the elderly (54%) were under age 75; one-third (34%) were between ages 75 and 84; and the remaining 12% were 85 and over.

As shown in Table 3.4b, the proportion of Medicare beneficiaries who are women increases substantially with age.

TABLE 3.4a. Age Distribution of Medicare Beneficiaries, 1996

	Beneficiaries (in thousands)
Elderly	33,404
65–74 years	18,031
75–84 years	11,408
85+ years	3,965
Disabled	4,688
Under 45 years	1,610
45–54 years	1,317
55–64 years	1,760
All beneficiaries	38,092

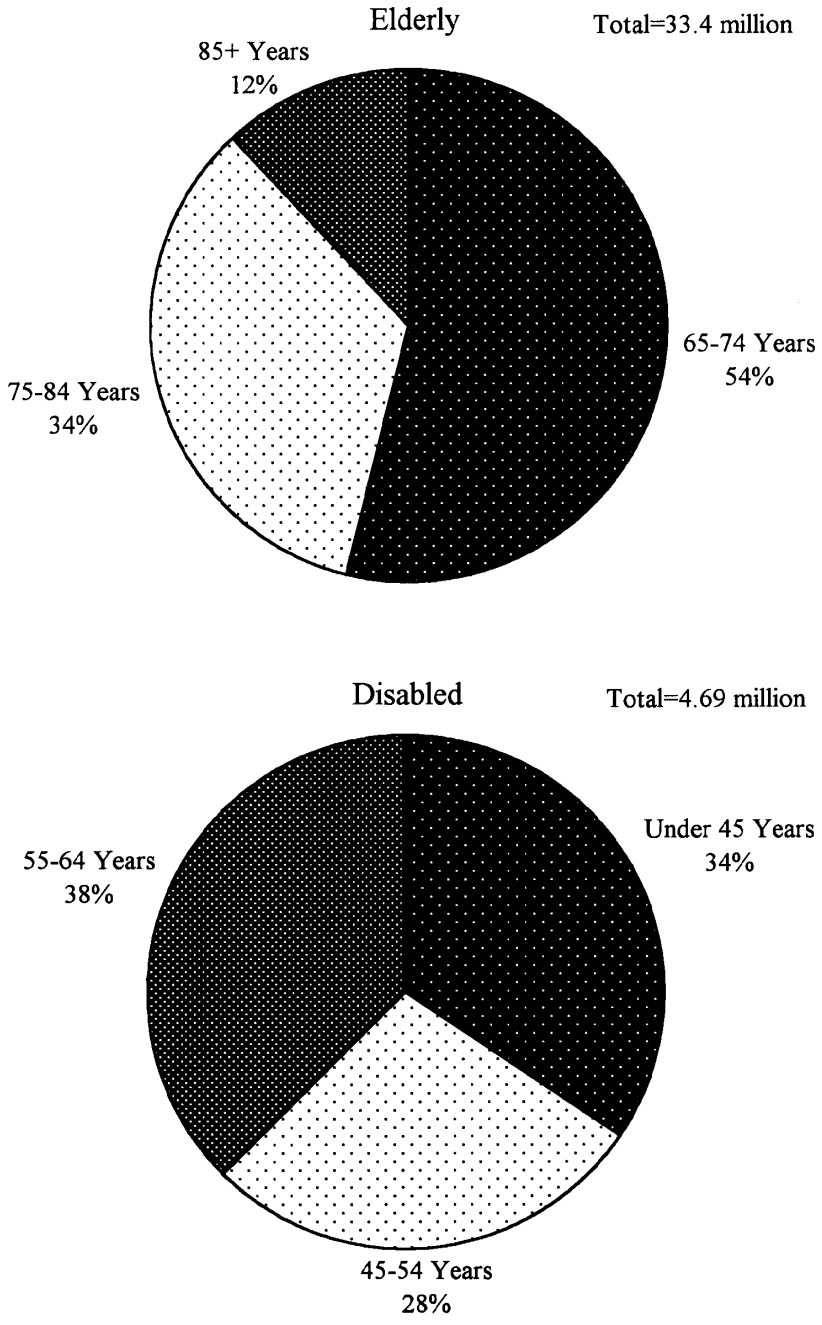
Note: Table prepared by CRS.

TABLE 3.4b. Gender Composition of Elderly Medicare Beneficiaries, 1996

	Percent of Beneficiaries Who Are Women
65–74 years	55.3
75–84 years	61.3
85+ years	72.2

Note: Table prepared by CRS.

Figure 3.4. Age Distribution of Medicare Beneficiaries, 1996

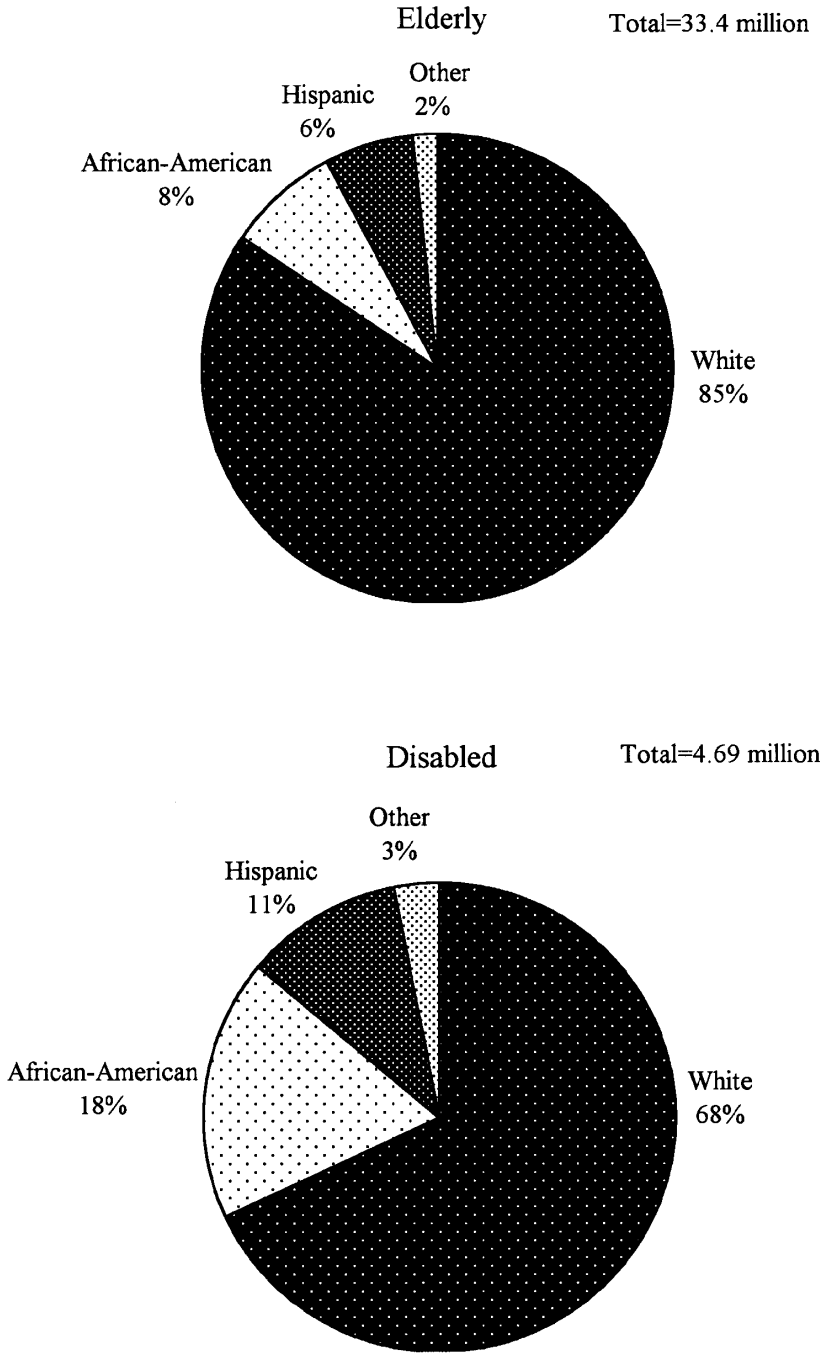


Source: Figure prepared by CRS based on HCFA, *1997 HCFA Statistics.*

Figure 3.5.
Race/Ethnicity Distribution of Medicare Beneficiaries, 1996

The great majority of Medicare beneficiaries are white. Eighty-five percent of the elderly and 68% of the disabled are white. African-Americans and hispanics constitute a larger percentage of the disabled population (18% and 11%) than of the elderly population (8% and 6%).

Figure 3.5. Race/Ethnicity Distribution of Medicare Beneficiaries, 1996



Source: Figure prepared by CRS based on HCFA, Office of Strategic Planning, *"A Profile of Medicare Chart Book, 1998."*

Figure 3.6.
Medicare Enrollment, Actual and Projected, 1966–2017

Medicare enrollment grew from 19.1 million persons in 1966 to an estimated 38.6 million persons in 1997. The elderly Medicare population grew from 19.1 million to 33.7 million over this period.

The program began covering the disabled in 1973. The disabled population grew from 2.2 million in 1975 to 4.9 million in 1997.

Total Medicare enrollment increased at an average annual rate of 1.8% over the FY1980–FY1990 period and 1.7% over the FY1990–FY1997 period. Elderly enrollment increased at an average annual rate of 1.9% for the FY1980–FY1990 period and 1.2% for the FY1990–FY1997 period. Very different trends were recorded for the disabled. While the average annual enrollment rate for the disabled was only 1% for the FY1980–FY1990 period, it climbed to 5.8% for the FY1990–FY1997 period.

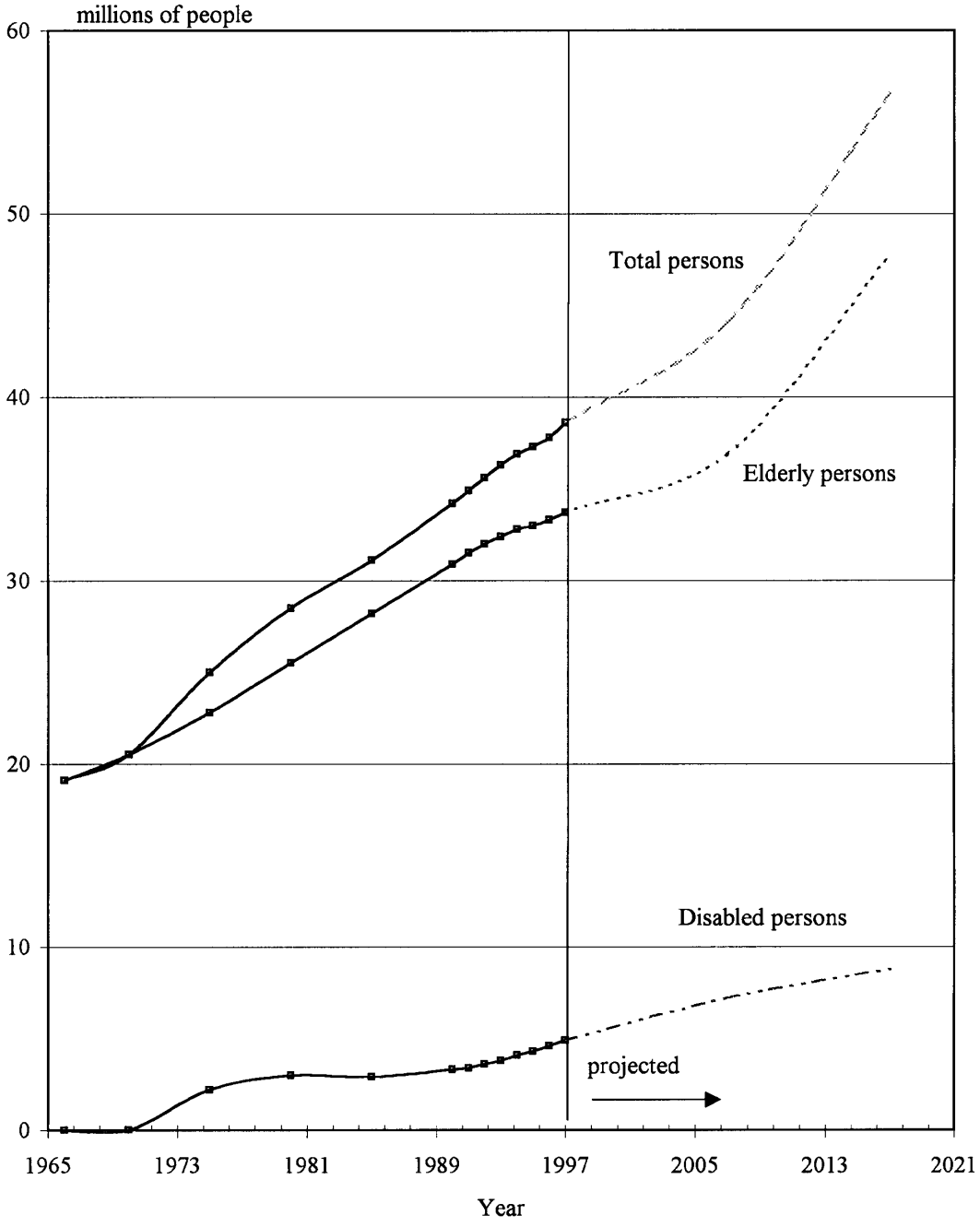
TABLE 3.6. Medicare Enrollment, Actual and Projected, 1966–2017

(in millions)

Year	Total Persons	Elderly Persons	Disabled Persons
1966	19.1	19.1	—
1970	20.5	20.5	—
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1990	34.2	30.9	3.3
1991	34.9	31.5	3.4
1992	35.6	32.0	3.6
1993	36.3	32.4	3.8
1994	36.9	32.8	4.1
1995	37.3	33.0	4.3
1996	37.8	33.3	4.6
1997	38.6	33.7	4.9
2007	44.1	36.9	7.2
2017	56.6	47.8	8.8

Note: Medicare coverage was extended to the disabled in 1973. Table prepared by CRS.

Figure 3.6. Medicare Enrollment, Actual and Projected, 1966-2017



Source: Figure prepared by CRS based on *1997 HCFA Statistics*.
NOTE: Medicare coverage was extended to the disabled in 1973.

Figure 3.7.
The Aging of the U.S. Population, 1960–2030

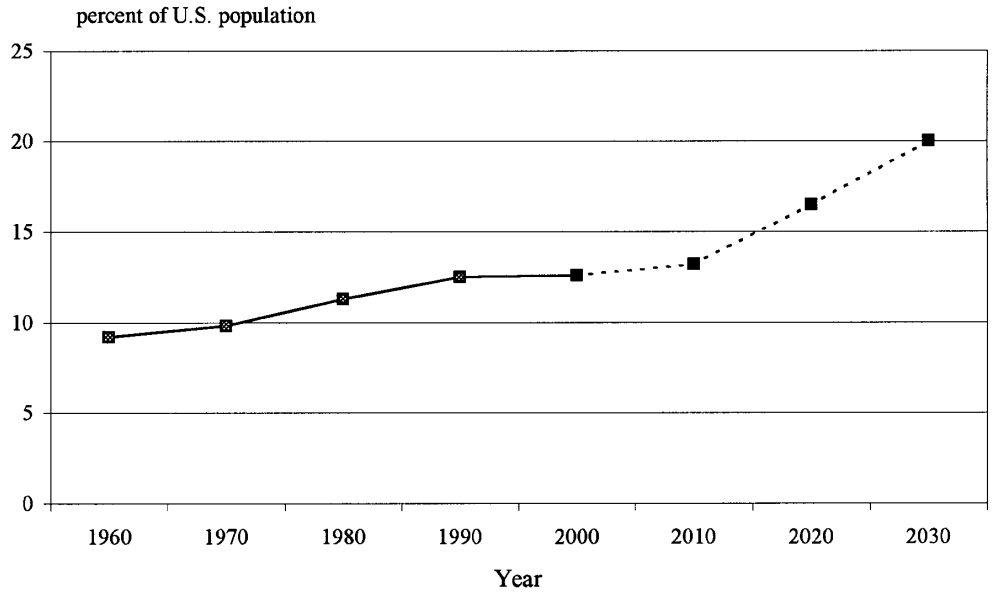
The U.S. population is aging. In 1960, 16.6 million persons were age 65 or over; this represented 9.2% of the population. In 1990, the number of aged persons had almost doubled (31.2 million persons) while the aged's percentage of the population had climbed to 12.5%. Both the number and percentage of aged persons is expected to climb rapidly after 2010 as the first wave of the baby boomers turns 65. By 2030, as the last of the baby boomers reaches 65, an estimated one-fifth of the population (over 69 million persons) will be aged.

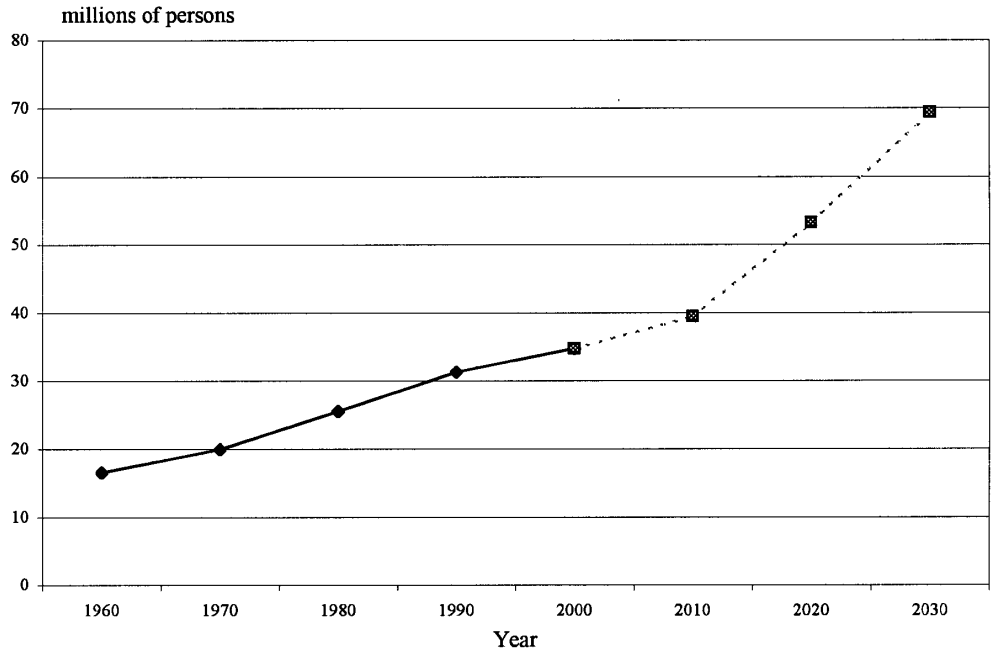
TABLE 3.7. The Aging of the U.S. Population, 1960–2030

Year	Number of Persons 65 Plus Years (in millions)	Percent of Population 65+
1960	16.56	9.2%
1970	19.98	9.8
1980	25.55	11.3
1990	31.24	12.5
2000 (est.)	34.71	12.6
2010 (est.)	39.41	13.2
2020 (est.)	53.22	16.5
2030 (est.)	69.38	20.0

Note: Table prepared by CRS.

Figure 3.7 The Aging of the U.S. Population, 1960-2030





Source: Figure prepared by CRS based on U.S. Department of Commerce, Census Bureau Current Population Reports, Population Projections of the U.S.: 1995 to 2050 (2/96); and Sixty-Five Plus in America; 5/93.

Figure 3.8.
Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1995

Over 70% of elderly Medicare beneficiaries reported incomes of less than $25,000 in 1995; close to 30% reported incomes of less than $10,000. The disabled reported even lower incomes: over one-half under $10,000, and 84% under $25,000.

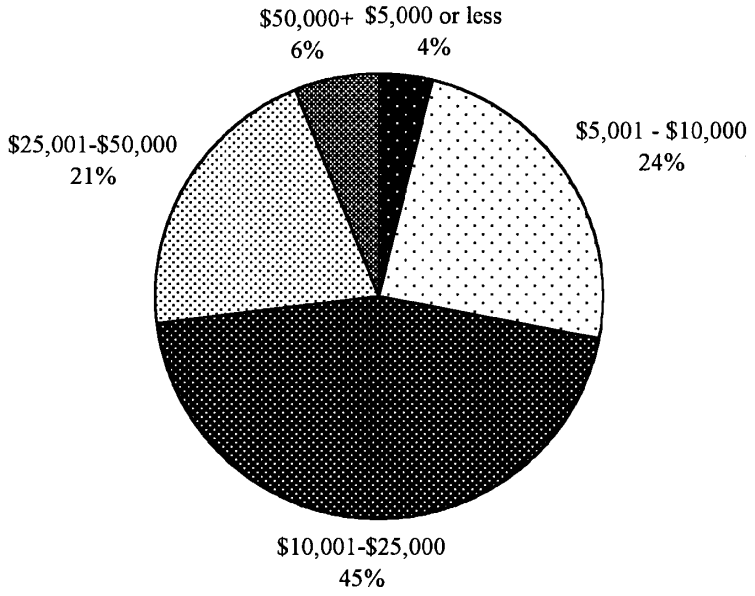
TABLE 3.8. Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1995

Income	Elderly (in percent)	Disabled (in percent)
$5,000 or less	4	9
$5,001–$10,000	24	46
$10,001–$25,000	45	29
$25,001–$50,000	21	13
$50,000+	6	3

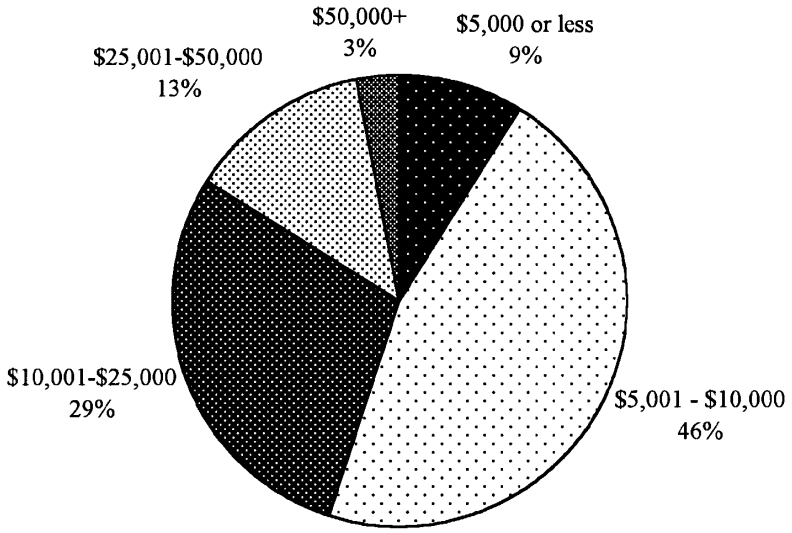
Note: Totals may not add due to rounding. Table prepared by CRS.

Figure 3.8. Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1995

Elderly



Disabled



Source: Figure prepared by CRS based on HCFA, Office of Strategic Planning, *"A Profile of Medicare Chart Book, 1998."*

Figure 3.9.
Percent of Poor Persons in the U.S. Population, 1959–1996

From 1959–1996, the percentage of the U.S. population below the poverty line declined from 22.4 to 13.7. An even more dramatic decline was recorded in the poverty rate for the elderly, dropping from 35.2% to 10.8%; however, the 1996 rate reflected a slight increase over the 1995 rate of 10.5. A less dramatic decline was recorded for children over the 1959–1996 period; the percentage for this group declined from 26.9 to 20.2.

While the rates for both the elderly and children were higher than that for the general population in 1959, the rate for the elderly was below that of the general population in 1996. Conversely, the rate for children in 1996 was considerably above that for the general population and substantially larger than that for the elderly.

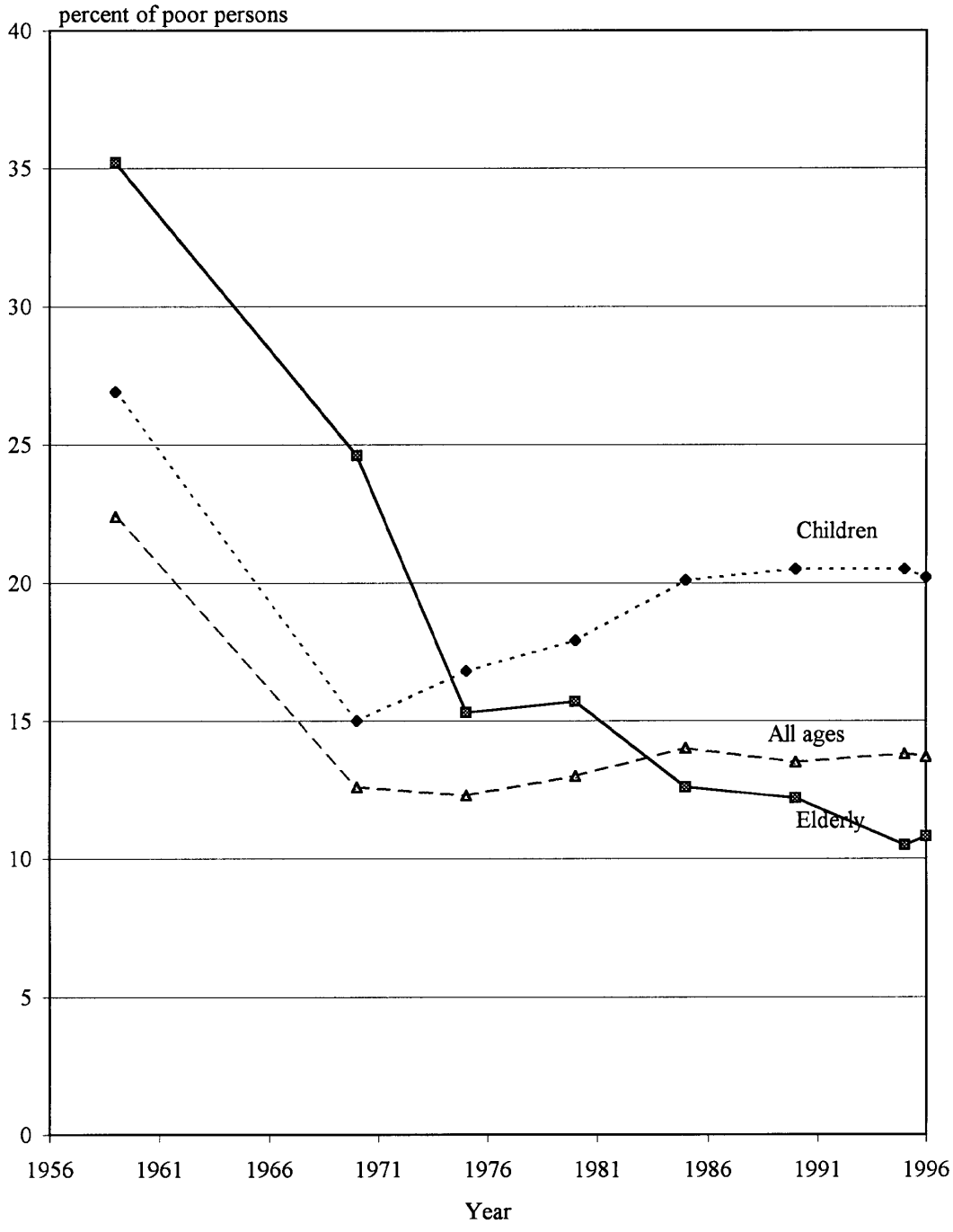
The poverty rate for the elderly has improved over the years, largely as a result of Social Security and a maturing pension system. The aged tend to be more immune to the effects of recession than others.

TABLE 3.9. Percent of Poor Persons in the U.S. Population, 1959–1996

Year	Children	Elderly	All Ages
1959	26.9	35.2	22.4
1970	15.0	24.6	12.6
1975	16.8	15.3	12.3
1980	17.9	15.7	13.0
1985	20.1	12.6	14.0
1990	20.5	12.2	13.5
1995	20.5	10.5	13.8
1996	20.2	10.8	13.7

Note: Table prepared by CRS.

Figure 3.9. Percent of Poor Persons in the U.S. Population, 1959-1996



Source: Prepared by CRS based on *Social Security Bulletin, Annual Statistical Supplement*, 1998.

Figure 3.10.
Distribution of Medicare Benefit Payments by Service Category, FY1997

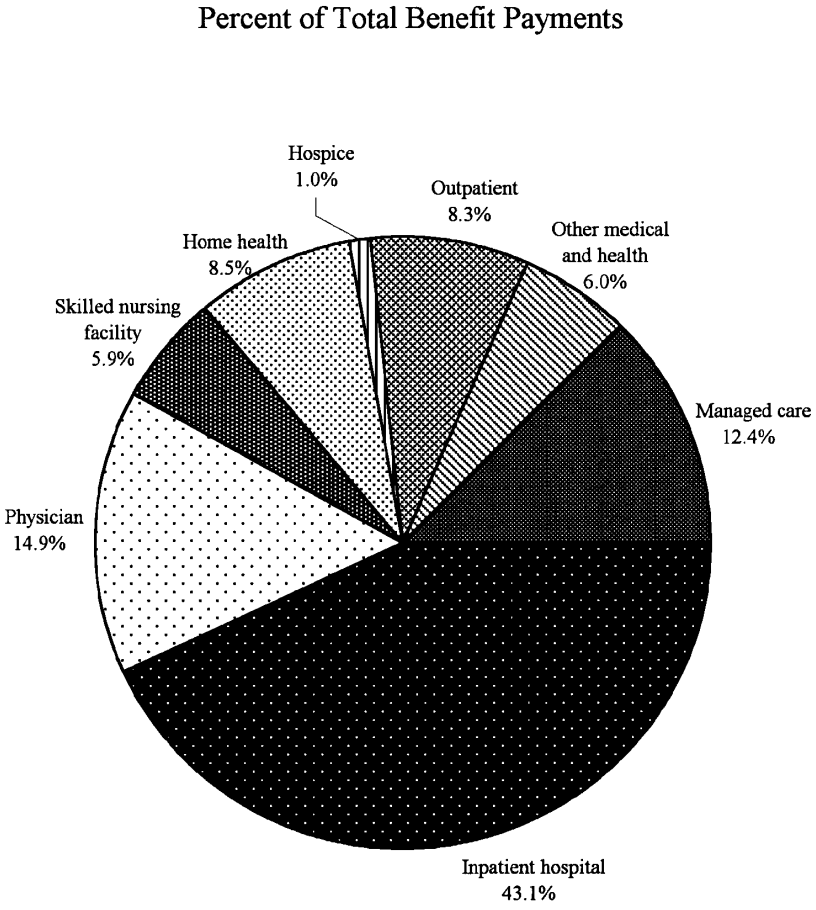
Close to 58% of Medicare benefit payments in FY1997 were for inpatient hospital services and physicians' services. Services provided by skilled nursing facilities, home health agencies, and hospices accounted for over 15%, while outpatient hospital services and other medical and health services accounted for over 14% of Medicare benefit payments. Managed care accounted for 12% of the total.

TABLE 3.10. Distribution of Medicare Benefit Payments by Service Category, FY1997

Service Category	Percent of Total Benefit Payments	Benefit Payments (in billions)
Fee-for-service	87.6	$181.5
Inpatient hospital	43.1	89.3
Physician	14.9	30.8
Skilled nursing facility	5.9	12.2
Home health	8.5	17.5
Hospice	1.0	2.1
Outpatient	8.3	17.1
Other medical and health	6.0	12.5
Managed care	12.4	25.6
Total	100.0	$207.0

Note: Table prepared by CRS; total may not add due to rounding.

Figure 3.10. Distribution of Medicare Benefit Payments by Service Category, FY1997



Source: Figure prepared by CRS based on CBO, *The Economic and Budget Outlook, 1998-2008 (Jan. 1998).*

Figure 3.11.
Trends in Distribution of Fee-For-Service Medicare Payments for Selected Services, FY1980 and FY1997

Payments for inpatient hospital services have represented a declining proportion of fee-for-service, as well as total, Medicare benefit payments since 1980. The percentage of total payments attributable to skilled nursing facility and home health benefits has increased over the period, while that for physicians services and related medical services has remained relatively constant

These trends reflect the fact that the growth rates in spending for hospital and physicians services have slowed significantly in response to the introduction of new payment systems. In FY1984, Medicare began paying for hospital services under the prospective payment system. In 1992, Medicare began to pay for physicians services on the basis of a fee schedule. In contrast, skilled nursing facility services and home health services continued to be paid on a reasonable cost basis; payments for these services have continued to rise at a much faster rate than those for hospital and physicians services. BBA 97 provided for the implementation of prospective payment systems for both skilled nursing facility and home health services. This is expected to slow the rate of growth in payments for these service categories.

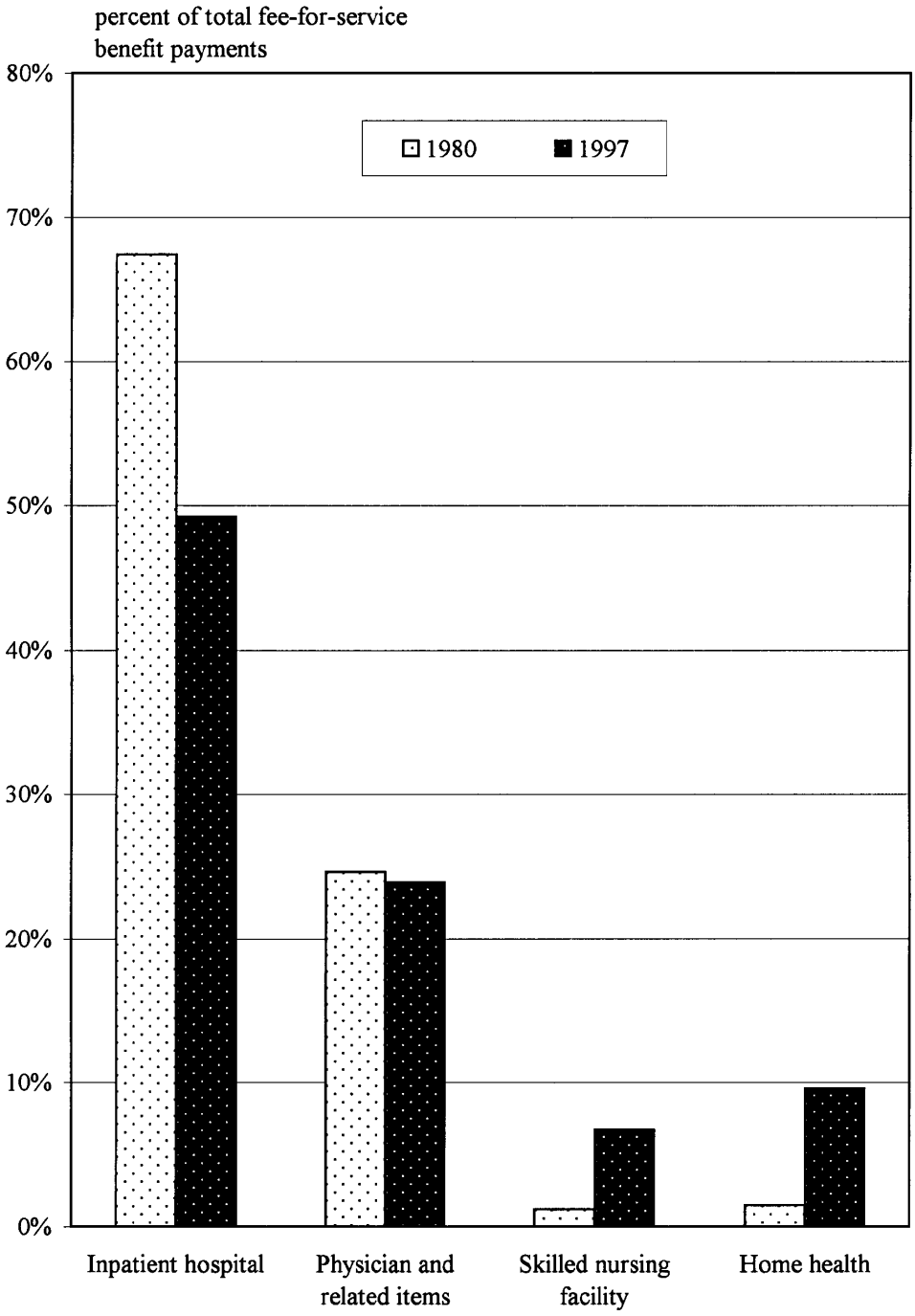
TABLE 3.11. Trends in Distribution of Fee-For-Service Medicare Payments for Selected Services, FY1980 and FY1997

(in percent)

Selected Services	1980	1997
Inpatient hospital	67.4	49.2
Physician and related items	24.6	23.9
Skilled nursing facility ...	1.2	6.7
Home health	1.5	9.6

Note: Data for 1980 may include limited expenditures for managed care. Table prepared by CRS.

Figure 3.11. Trends in Distribution of Fee-for-Service Medicare Payments for Selected Services, FY1980 and FY1997



Source: Figure prepared by CRS based on House Ways and Means, *1996 Green Book,* and CBO, *The Economic and Budget Outlook, 1998-2008 (Jan. 1998).*

Figure 3.12.
Average Annual Medicare Growth Rates, FY1990–FY1996 and FY1997–FY2002

There is wide variation in the average annual growth rates for various service categories. In recent years, the expenditures for skilled nursing facility (SNF) services, home health services, and hospice care have been growing considerably faster than have other fee-for-service expenditures such as those for inpatient hospital, outpatient hospital, and physician services. Expenditures for managed care have also increased at significant rate; this reflects the increasing number of beneficiaries enrolled in managed care plans.

The BBA 97 reduced the rate of growth in Medicare spending. As a result, the expected average annual increase in spending by benefit category is expected to slow significantly over the FY1997–FY2002 period.

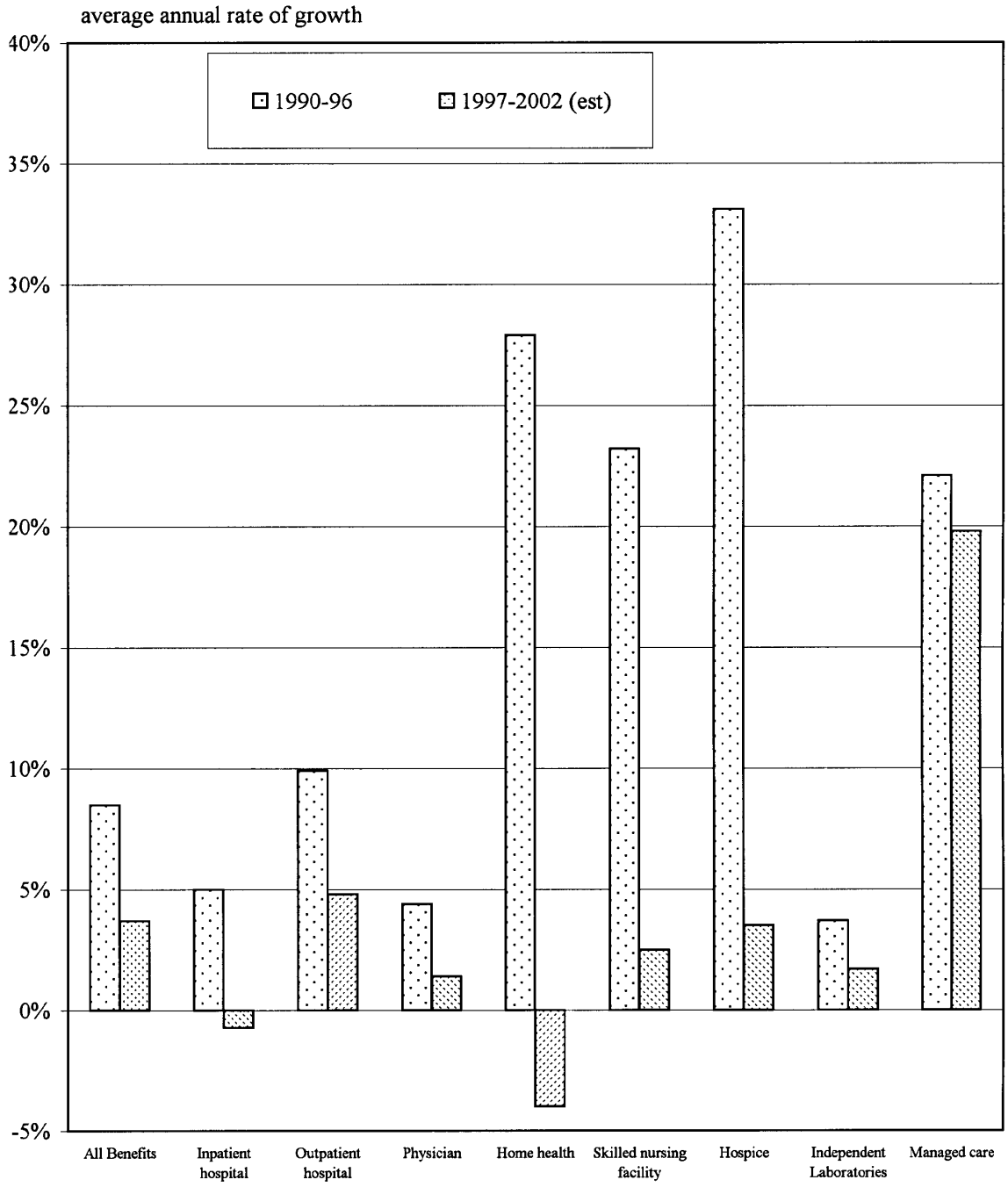
TABLE 3.12. Average Annual Medicare Growth Rates, FY1990–FY1996 and FY1997–FY2002

(in percent)

	1990–96	1997–2002 (est)
All benefits	8.5	3.7
Inpatient hospital	5.2	−0.7
Outpatient hospital	9.9	4.8
Physician	4.4	1.4
Home health	27.9	−4.0
Skilled nursing facility	23.2	2.5
Hospice	33.1	3.5
Independent laboratories	3.7	1.7
Managed care	22.1	19.8

Note: Table prepared by CRS.

Figure 3.12. Average Annual Medicare Growth Rates FY1990-FY1996 and FY1997-FY2002



Source: Figure prepared by CRS based on HCFA, Office of the Acutary, unpublished date (Feb. 1998).

Figure 3.13.
Medicare Short-Stay Hospital Utilization, Selected Fiscal Years, 1985–1997

Since FY1984 Medicare has paid for acute, or short-stay, hospital care on the basis of a prospective payment system (PPS). Under Medicare's PPS for inpatient care, hospital payment amounts are established in advance of the provision of services on the basis of a patient's diagnosis. The system's fixed prices are determined using a classification system of 511 diagnosis-related groups (DRGs). Each Medicare inpatient case is assigned to one of the 511 DRGs based on the patient's medical condition and diagnosis at admission.

While discharge rates per 1,000 Medicare enrollees remained fairly constant during the 1990s, days of care and average length of stay have decreased significantly over the same period. Between 1990 and 1997, total days of care dropped from 94 million to 75 million, a decrease of 20%. Average length of stay also declined from 9.0 days in 1990 to 6.4 days in 1997, a decrease of almost 29%.

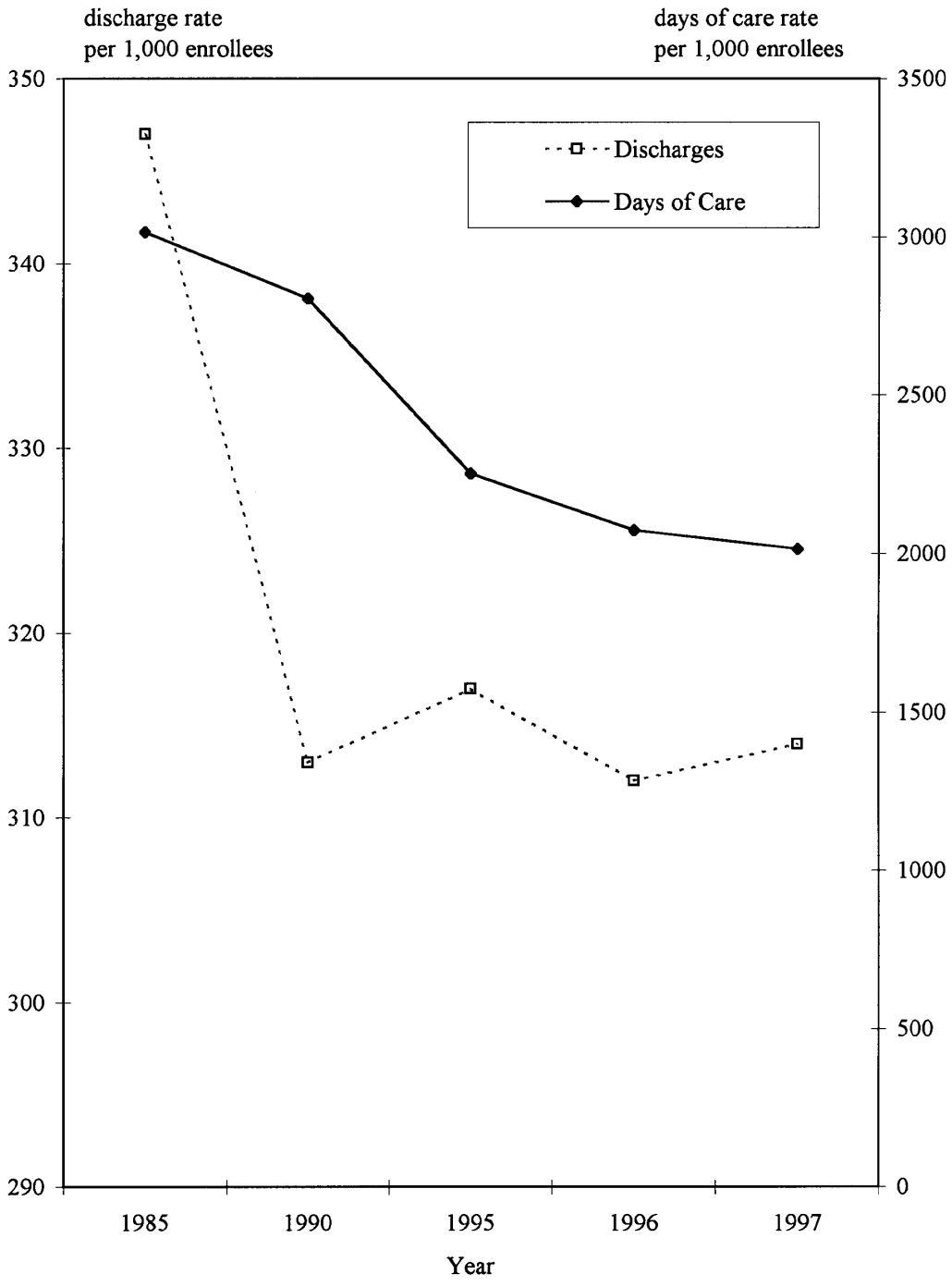
TABLE 3.13. Medicare Short-Stay Hospital Utilization, Selected Fiscal Years, 1985–1997

	1985	1990	1995	1996	1997*
Discharges					
Total in millions	10.5	10.5	11.7	11.7	11.8
Rate per 1,000 enrollees	347	313	317	312	314
Days of care					
Total, in millions	92	94	83	78	75
Rate per 1,000 enrollees	3,016	2,805	2,253	2,074	2,014
Average length of stay					
All short-stay (in days)	8.7	9.0	7.1	6.7	6.4

Note: Table prepared by CRS.

*Preliminary data.

Figure 3.13. Medicare Short-Stay Hospital Utilization, Selected Fiscal Years, 1985-1997



Source: Figure prepared by CRS based on *1998 HCFA Data Compendium*.

Figure 3.14.
Medicare Funding for Graduate Medical Education, 1990–1998

Medicare recognizes as reasonable the extra costs of graduate medical education (GME), or medical residency training activities incurred by teaching hospitals. The Medicare program pays for its share of GME costs through two payment mechanisms: the indirect medical education (IME) adjustment, and the direct graduate medical education (direct GME) payment. The IME adjustment is designed to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The direct GME payment is designed to reimburse teaching hospitals for Medicare's share of the costs of salaries and fringe benefits paid to residents, interns, and teaching faculty, and certain overhead costs relating to teaching activities.

The BBA 97 includes several reforms of Medicare's payments for GME. First, the IME adjustment is reduced from 7.7% to 7.0% in FY1998; 6.5% in FY1999; 6.0% in FY2000; and to 5.5% in FY2001 and subsequent years. Second, the BBA 97 phases out Medicare GME support from premiums paid to managed care plans and pays these monies directly to teaching hospitals that treat Medicare managed care patients. The BBA 97 also caps the number of medical residents supported by Medicare at the December 31, 1996 level. Finally, the BBA 97 also makes a number of changes to the direct GME payments, including allowing non-hospital providers to receive such funds, and creating voluntary residency reduction programs.

IME payments[4] rose from $2.91 billion in FY1990 to $4.99 billion in FY1998. Total direct GME payments[5] increased from $1.76 billion in FY1990 to $2.10 billion in FY1998.

TABLE 3.14. Medicare Funding for Graduate Medical Education, 1990–1998

($ in billions)

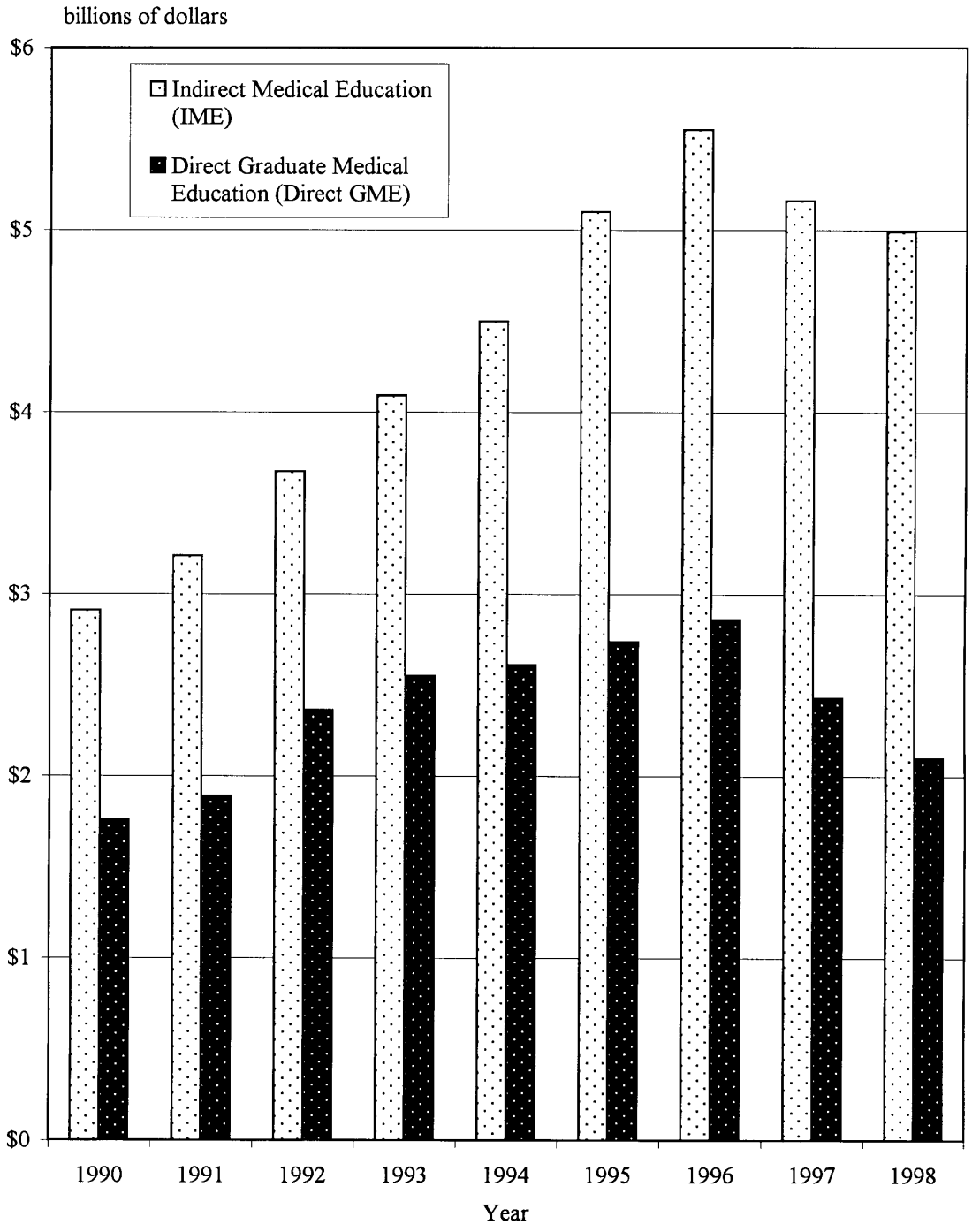
Year	IME	Direct GME	Total GME
1990	2.91	1.76	4.67
1991	3.21	1.89	5.10
1992	3.67	2.36	6.03
1993	4.09	2.55	6.64
1994	4.50	2.61	7.11
1995	5.10	2.74	7.84
1996	5.55	2.86	8.41
1997	5.16	2.43	7.59
1998	4.99	2.10	6.09

Note: Table prepared by CRS.

[4] IME amounts include payments for capital costs and payments to managed care plans.

[5] Direct GME amounts include payments for certain hospital-operated nursing and allied health professions education and training programs.

Figure 3.14. Medicare Funding for Graduate Medical Education, 1990-1998



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary.

Figure 3.15.
Trend in Number of Medical Residents,[6] 1990/91–1997/98

In the rapidly changing health care market, the supply of physicians and the mix of specialties they practice continue to be of concern to policymakers. An oversupply of physicians and an imbalance in specialty mix can contribute to the growth in health care costs. The growth of managed care has also contributed to the concern about whether or not the correct mix of physician specialties are being trained. Generally, there is concern that too many specialist and not enough primary care physicians are being trained.

Medicare currently pays for residency training without regard to specialty.[7] Some argue that because Medicare is the only explicit payer of graduate medical education costs the program should play a larger role in shaping the physician workforce. The BBA 97 includes several GME reforms which are designed to address some of the concerns about residency training supported by Medicare. These provisions include: (1) a cap on the total number of residents supported by Medicare; (2) payments to non-hospital providers for direct GME costs; and (3) incentive payments to teaching hospitals for reducing the size of their residency training programs.

There is some evidence that the market for physicians is changing slightly in response to general health care market forces. The total number of residents increased each year through school year 1995–1996, but may now be on a downward trend. Part of this trend, however, may be attributed to changes in the data collection methods.

TABLE 3.15. Trend in Number of Medical Residents, 1990–1998

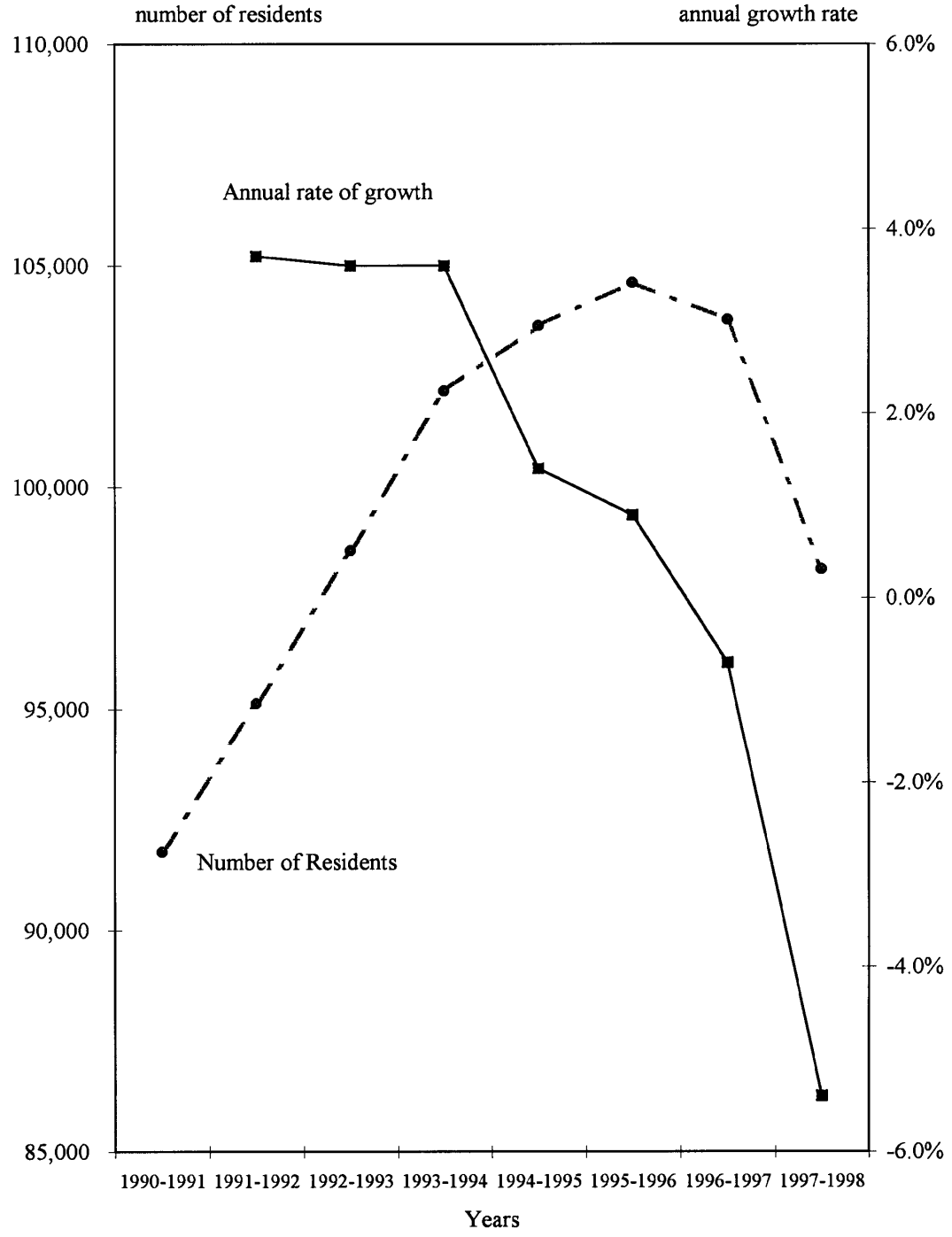
School Years	Number of Residents	Annual Growth Rates (in percent)
1990–1991	91,766	—
1991–1992	95,130	3.7
1992–1993	98,573	3.6
1993–1994	102,168	3.6
1994–1995	103,640	1.4
1995–1996	104,609	0.9
1996–1997	103,777	−0.7
1997–1998	98,138	−5.4

Note: Table prepared by CRS, based on data collected by Association of American Colleges.

[6] The data presented for medical residents includes residents in allopathic (M.D.) residency programs only.

[7] Medicare pays for its share of the direct cost of GME. For residents in their initial residency period, defined as the minimum number of years required to become board certified and not to exceed 5 years, Medicare counts each full-time-equivalent (FTE) resident as 1.0 FTE. For residents beyond their initial residency period, Medicare counts each resident as 0.5 FTE. There is a special exception for residents in accredited geriatrics training programs that allows these residents to be counted as 1.0 FTE for an additional 2 years.

Figure 3.15. Trend in Number of Medical Residents, 1990/91-1997/98



Source: Figure prepared by CRS based on data provided by the Association of American Medical Colleges.

Figure 3.16.
Selected Primary Care Residents as a Percent of Total Residents, 1990–1991 and 1997–1998

The specialty mix of residents has been an important concern for GME reform. Many experts look to the specialty choices of medical residents as an indication of the changing health care marketplace and how it will affect the future physician workforce. When considering the number of residents training in primary care, it is important to keep in mind that many residents who undergo training in a primary care specialty may go on to subspecialize and may not practice in primary care once their training is completed.

The number of residents in selected[8] primary care specialties grew from 26,093 in 1990–1991, to 39,767 in 1997–1998, a 52.4% increase. First-year residents in selected primary care specialties also grew from 10,796 in 1990–1991 to 14,809 in 1997–1998, a 37.2% increase.

Both the total number of residents in primary care and first year residents in primary care increased from 1996–1997 to 1997–1998. When compared to the total number of residents, the proportion of residents in primary care specialties grew from 28.4% in 1990–1991 to 38.3% in 1997–1998.

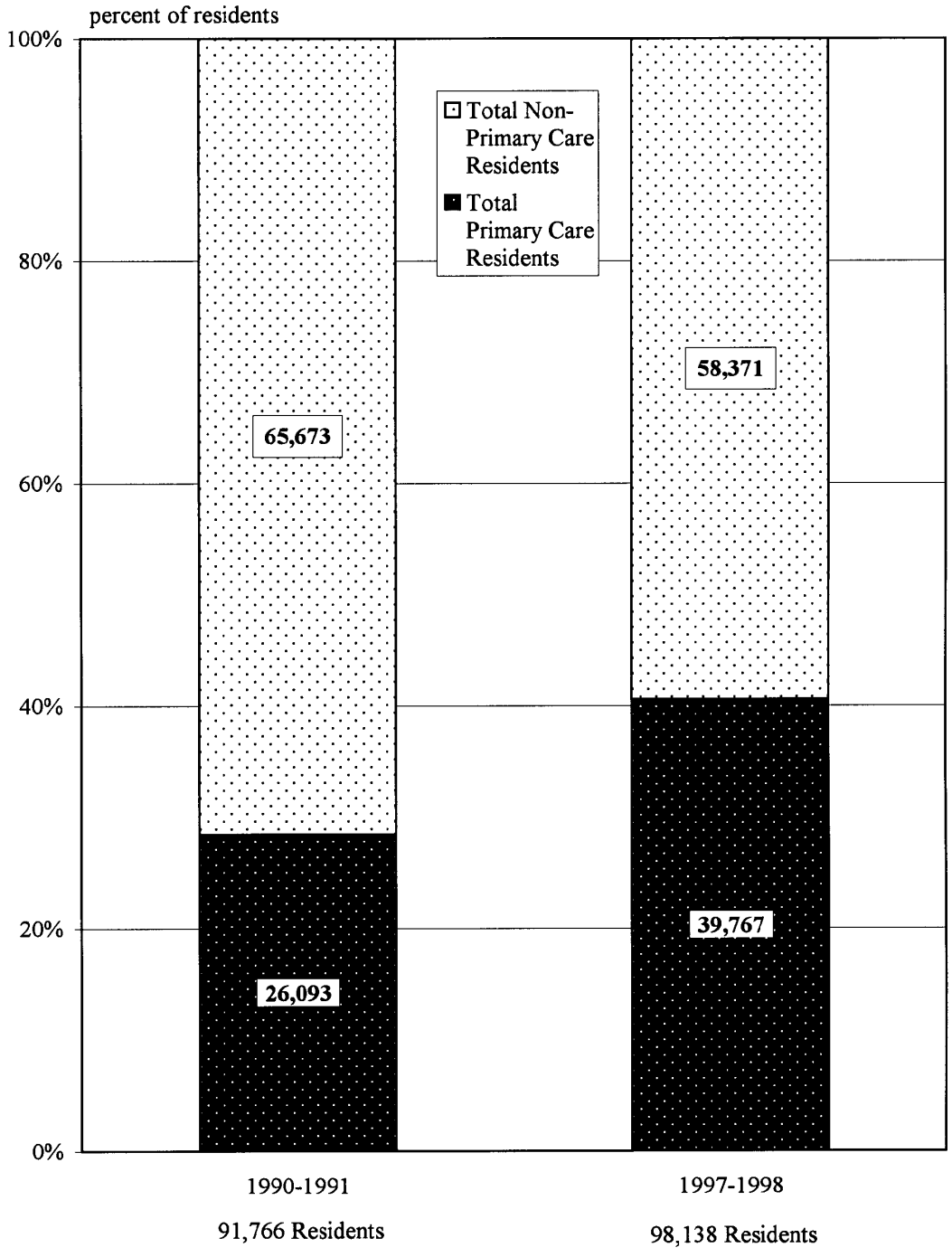
TABLE 3.16. Selected Primary Care Residents and First-Year Residents, 1990–1991 and 1997–1998

Specialty	Primary Care Residents		First-Year Primary Care Residents	
	1990–1991	1997–1998	1990–1991	1997–1998
Family practice	7,183	10,369	2,407	3,577
Family practice—geriatrics	17	22	N.A.	N.A.
Internal medicine (general)	11,883	21,574	6,070	8,396
Internal medicine—geriatrics	177	240	N.A.	N.A.
Pediatrics (general)	6,833	7,520	2,319	2,632
Total primary care	26,093	39,767	10,796	14,809

Note: Table prepared by CRS.

[8] Selected primary care residency programs include: family practice, family practice—geriatrics, internal medicine (general), internal medicine—geriatrics, and pediatrics (general).

Figure 3.16. Selected Primary Care Residents as a Percent of Total Residents, 1990-1991 and 1997-1998



Source: Figure prepared by CRS based on information provided by the Association of American Medical Colleges

Figure 3.17.
Trend in Medicare Payments for Skilled Nursing Facility (SNF) Care, 1988–1998

Medicare skilled nursing facility (SNF) spending increased dramatically between 1988, when payments were $900 million, and 1989 when payments soared to $3.5 billion. It has increased at an average annual rate of 17% since then, rising to over $13.8 billion in 1998.

The initial increase can be traced to two significant changes occurring in the late 1980s. First, the Health Care Financing Administration (HCFA) issued new coverage guidelines that became effective in 1988. These guidelines provided SNFs a great deal more information than had previously been available about criteria that must be met for a beneficiary to receive Medicare coverage. A second major, though temporary, change also came in 1988, with the enactment of the Medicare Catastrophic Coverage Act (MCCA). Effective beginning in 1989, this legislation eliminated the SNF benefit's prior hospitalization requirement and made several other changes. The MCCA was repealed in 1989, and the SNF benefits structure assumed its prior form.

Studies have suggested that the coverage guidelines and the MCCA changes together might have caused a long-run shift in the nursing home industry toward Medicare patients that did not end with the repeal of the MCCA. Between 1989 and 1997, the number of SNFs participating in the program increased from 8,638 to 14,619 or by 69%. In addition, during this same period, an increasing number of persons qualified for SNF care and reimbursements per day of care grew significantly, as explained in the next figure.

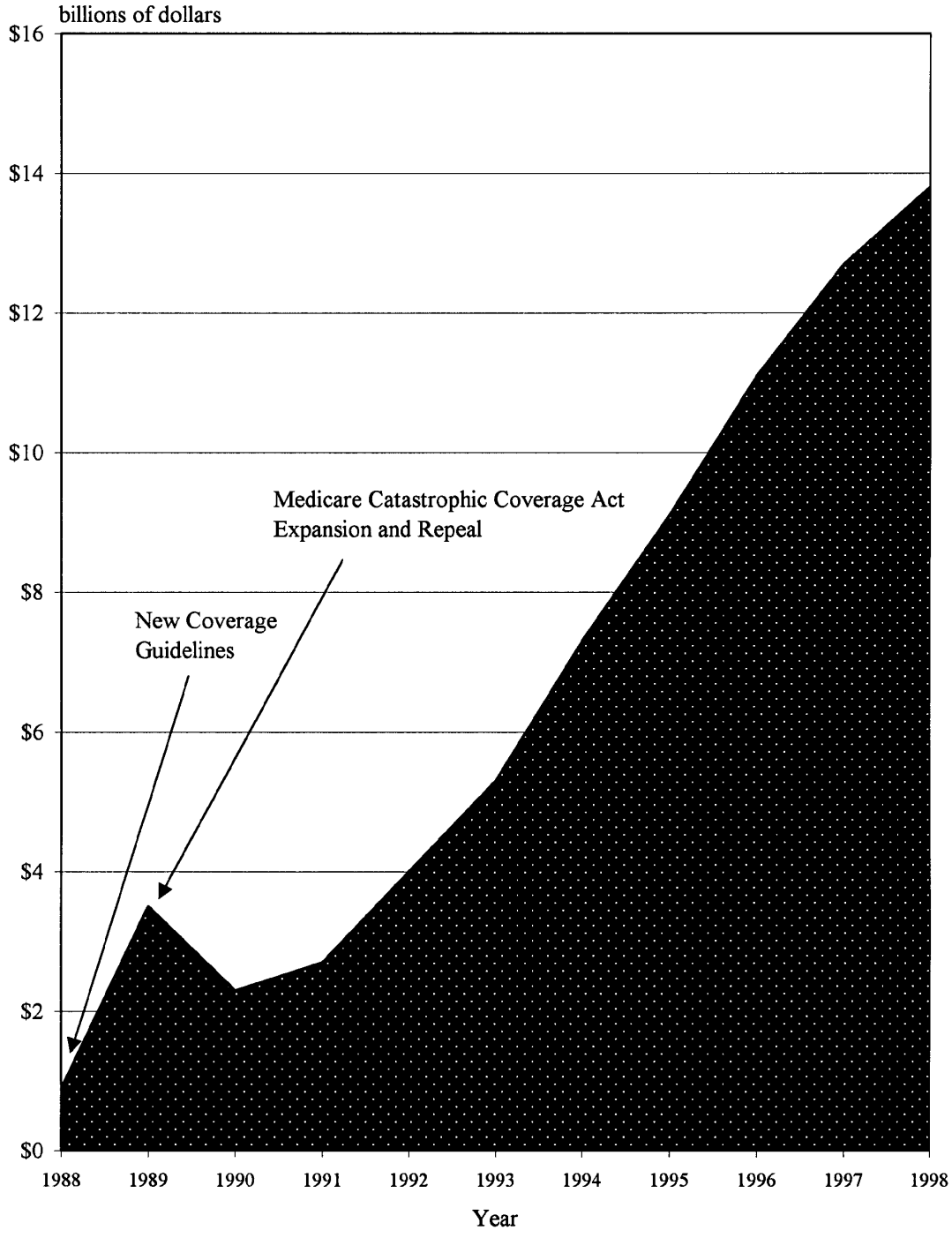
TABLE 3.17. Trend in Medicare Payments for Skilled Nursing Facility Care, 1988–1998

(fee-for-service only)

Calendar Year	Payments (in billions)	Percent Change
1988	$0.9	—
1989	3.5	275.7
1990	2.3	−33.1
1991	2.7	17.5
1992	4.0	45.8
1993	5.3	33.7
1994	7.3	36.8
1995	9.1	24.6
1996	11.1	21.9
1997	12.7	14.4
1998	13.8	8.6

Note: Total for 1998 is estimated. Rounding in payments may not reflect actual percentage change. Table prepared by CRS.

Figure 3.17. Trend in Medicare Payments for Skilled Nursing Facility (SNF) Care, 1988-1998



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary.

Figure 3.18.
Trends in SNF Utilization and Payments Per Day, 1988–1998

Growth in Medicare skilled nursing facility (SNF) spending can be explained largely by an increasing number of persons qualifying for the benefit and increases in reimbursements per day of care. From 1988 through 1998, persons receiving SNF care increased at an average annual rate of 16%; reimbursements per day of covered care increased on average by 12%. The average number of days per person served increased from about 28 days in 1988 to 32 days in 1998.

Since the start of 1992, the rate of growth in SNF use has been high because of declining lengths of stay in hospitals as well as an increasing supply of participating facilities. Medicare reimbursement policies explain much of the increase in reimbursements per covered day of care. Although routine care costs (nursing, room and board, administrative, and other overhead) have been subject to per diem limits, ancillary services (therapies, laboratory services, radiology procedures, supplies and other equipment) have not. However, this should change in 1999 as a 3-year phase-in of a prospective payment system for SNF care takes effect. This prospective payment system, established by BBA 97, will pay a fixed per diem rate for services provided to a Medicare beneficiary as a SNF patient. The per diem rate will include all SNF benefits (including routine, ancillary, and capital-related costs) as well as certain other Part B services the beneficiary is provided during a SNF stay. The actual per diem rate paid to a SNF for a given beneficiary will be based on a resident classification system that takes into account relative resource utilization of different patient types; it will pay higher per diems for patients requiring a great deal of care and lower rates for those requiring less intensive care.

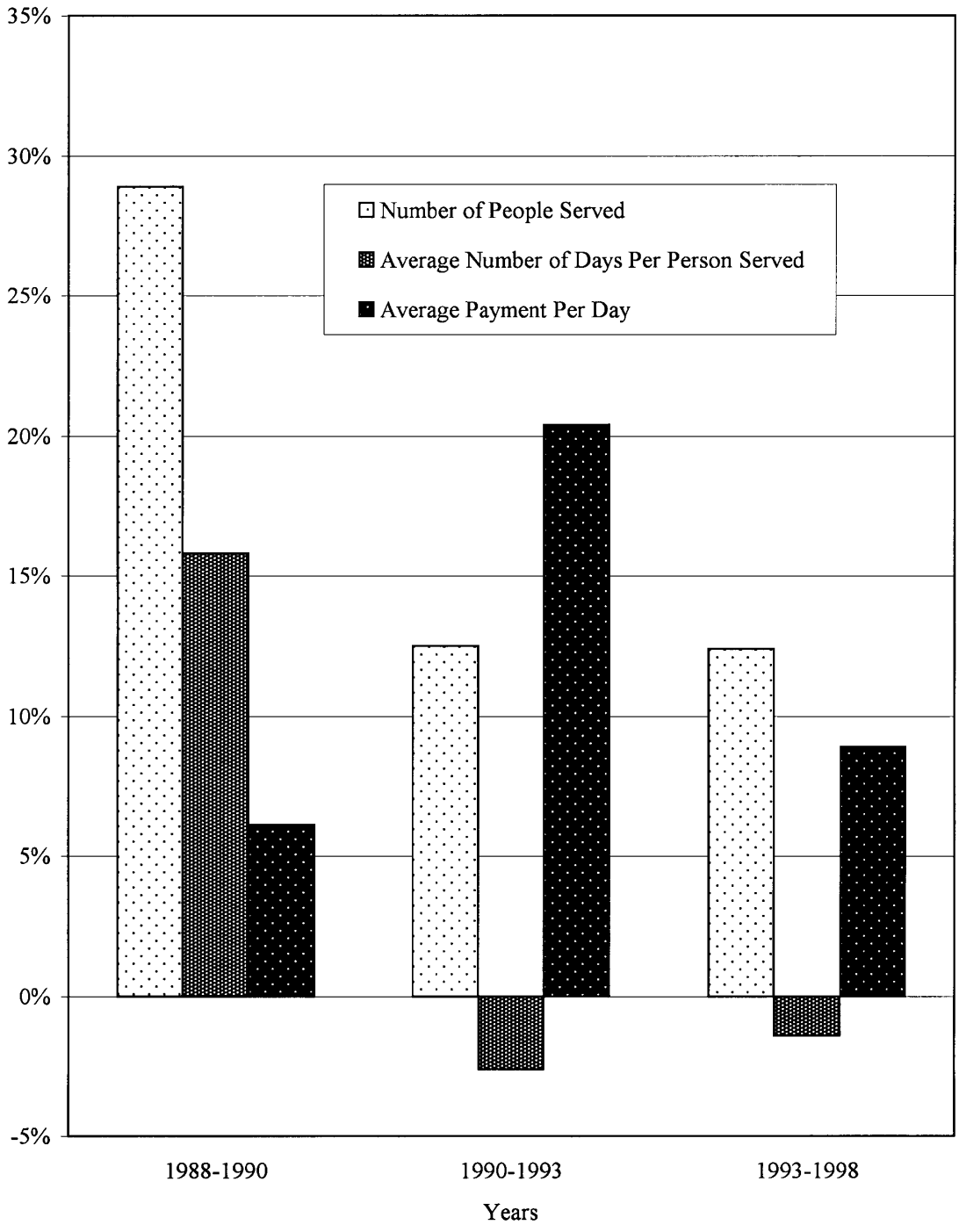
TABLE 3.18. Trends in SNF Utilization and Payments Per Day, 1988–1998

(fee-for-service only)

Calendar Year	Number of People Served	% Change	Average Number of Days per Person Served	% Change	Average Payment per Day (in dollars)	% Change
1988	384,000	—	27.8	—	$87	—
1989	636,000	65.6	46.8	68.4	117	34.5
1990	638,000	0.3	37.3	−20.3	98	−16.2
1991	671,000	5.2	33.2	−11.0	123	25.5
1992	785,000	17.0	34.4	3.6	148	20.3
1993	908,000	15.7	34.5	0.3	171	15.5
1994	1,068,000	17.6	35.6	3.2	192	12.3
1995	1,240,000	16.1	34.9	−2.0	211	9.8
1996	1,384,000	11.6	34.5	−1.2	233	10.4
1997	1,572,000	13.5	32.0	−7.3	253	8.5
1998	1,630,000	3.6	32.2	0.0	262	3.5

Note: During 1989 only, a prior hospitalization was not required for Medicare coverage of SNF care. Data for 1998 are preliminary and possibly incomplete. Rounding in payments may not reflect actual percentage change. Table prepared by CRS.

Figure 3.18. Trends in SNF Utilization and Payments Per Day, 1988-1998



Source: Figure prepared by CRS, based on data provided by HCFA, Office of the Actuary.

Figure 3.19.
Trend in Medicare Payments for Home Health, 1988–1998

Throughout the early 1990s, home health care was one of Medicare's fastest growing benefits. Spending increased from $2.0 billion in 1988 to $16.5 billion in 1998, for an average annual rage of growth of 24%. Factors that explain some of this growth include technological advances that make home care rather than hospital care possible, and a nearly two-fold increase in the number of home care agencies participating in Medicare, from 5,686 agencies in 1989 to 10,492 in 1997.

Some portion of the growth probably resulted from the incentives set up by the hospital prospective payment system to discharge patients more quickly to other settings. At first, HCFA reviews of care for these discharged patients resulted in high denial rates for home health care, but in 1989 the rules were relaxed and new guidelines liberalized coverage policies.

In response to the growth of home health care costs, Congress established in BBA 97 new limits for computing Medicare payments to home health agencies. One of these changes includes a new limit on payments per beneficiary that are applied in the aggregate. They were in effect through most of 1998, and the 1998 data reflect expected payment reductions. Further savings are anticipated when a prospective payment system is implemented for home health care after the start of the year 2000.

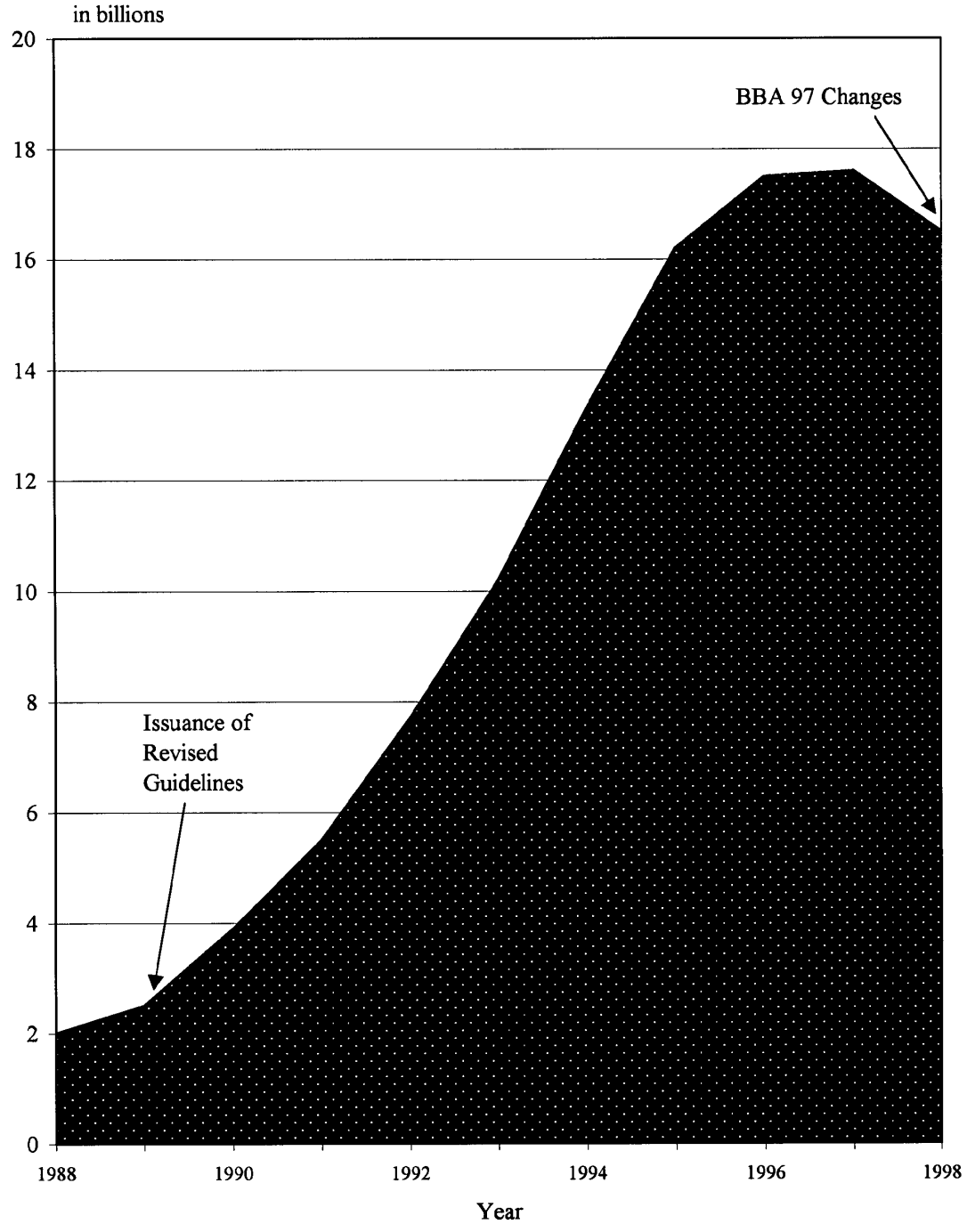
TABLE 3.19. Trend in Medicare Payments for Home Health, 1988–1998

(fee-for-service only)

Calendar Year	Payments (in billions)	Percent Change
1988	$2.0	—
1989	2.5	23.3
1990	3.9	53.2
1991	5.5	43.7
1992	7.7	39.5
1993	10.2	32.0
1994	13.3	30.1
1995	16.2	21.8
1996	17.5	8.0
1997	17.6	0.0
1998	16.5	−6.3

Note: Total includes both Part A and Part B payments. The total for 1998 is estimated. Rounding in payments may not reflect the actual percentage change. Table prepared by CRS.

Figure 3.19. Trend in Medicare Payments for Home Health, 1988-1998



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary.

Figure 3.20.
Trends in Medicare Home Health Care Utilization and Payments Per Visit, 1988–1997

Most of the growth in home health spending can be attributed to an increasing volume of services covered under the program, as measured by increases in the numbers of users as well as the number of covered visits per user. For the period 1988 through 1997, the number of users increased at an average annual rate of 10%, and the average number of visits per person served increased at the rate of 14% per year. During this same period, total Medicare enrollment increased by less than 2% per year. Increasing costs for home health services have accounted for comparatively little of the growth in spending. Payments per visit increased at an average annual rate of 1.5% from 1988 through 1997. Growth in the volume of home health services paid for by Medicare was highest from 1988 through 1993; the rate of growth has declined since 1994. The declining rate of growth in volume of visits reimbursed during this latter period can be explained in part by increasing numbers of beneficiaries enrolling in Medicare managed care plans; between 1993 and 1997 managed care enrollment increased from 5.3% to 14% of total Medicare enrollment. The program does not track utilization of individual covered benefits for persons enrolled in managed care. The absolute decrease in the average number of visits per person in 1997 reflects provisions in BBA 97 that established new payment limits for home health services aimed at controlling the volume of covered services beginning October 1, 1997.

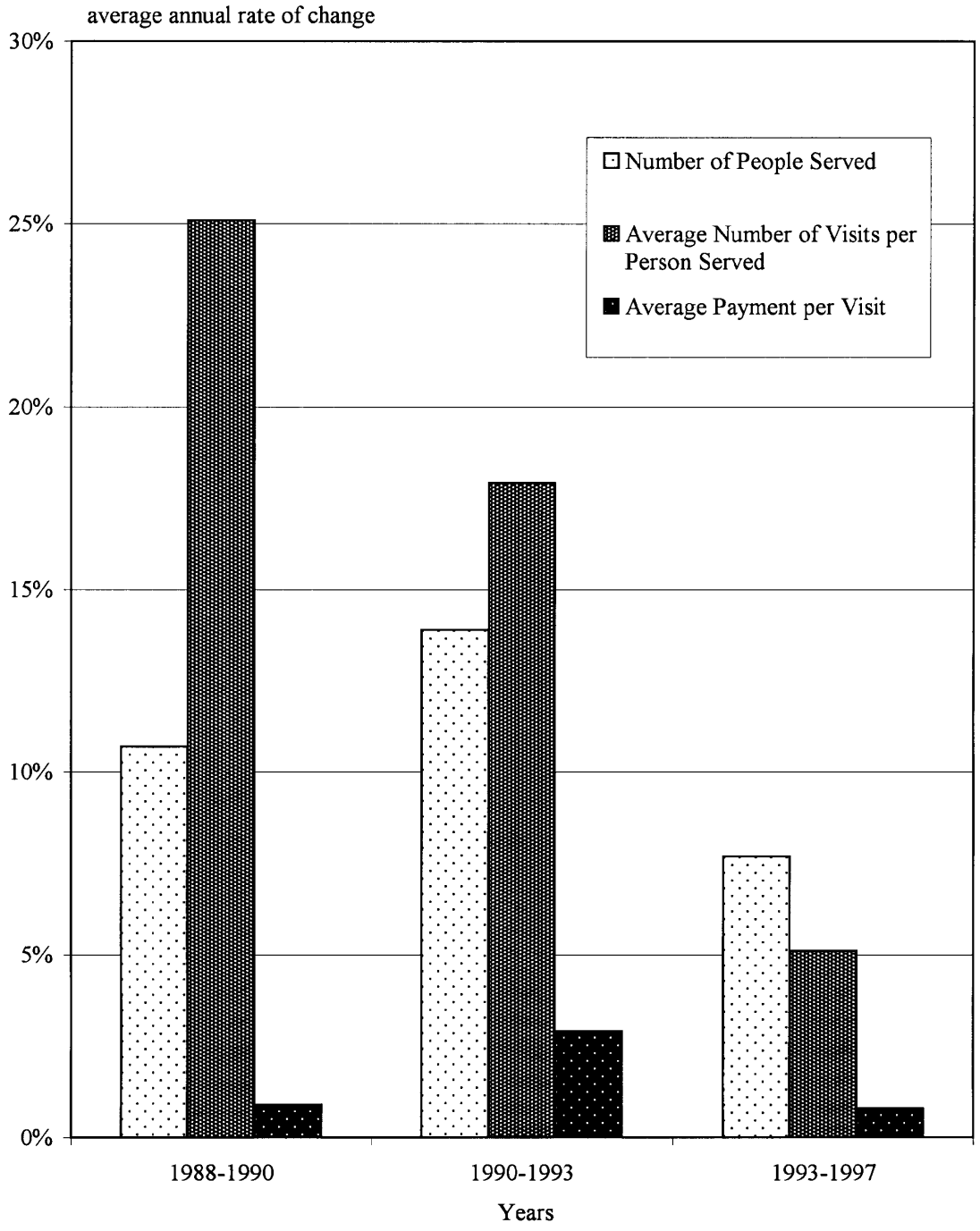
TABLE 3.20. Trends in Medicare Home Health Care Utilization and Payments Per Visit, 1988–1997

(fee-for-service only)

Calendar Year	Number of People Served	% Change	Average Number of Visits per Person Served	% Change	Average Payment per Visit (in dollars)	Change
1988	1,582,000	—	23	—	$55	—
1989	1,685,000	6.5	27	17.4	55	0.0
1990	1,940,000	15.1	36	33.3	56	1.8
1991	2,223,000	14.6	44	22.2	56	0.0
1992	2,523,000	13.5	53	20.5	58	3.6
1993	2,868,000	13.7	59	11.3	61	5.2
1994	3,175,000	10.7	69	17.0	60	−1.6
1995	3,457,000	8.9	77	11.6	60	0.0
1996	3,583,000	3.6	79	2.6	61	1.7
1997	3,865,000	7.8	72	8.9	63	3.2

Note: Rounding in payments may not reflect actual percentage change. Table prepared by CRS.

Figure 3.20. Trends in Medicare Home Health Care Utilization and Payments Per Visit, 1988-1997



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary.

Figure 3.21.
Home Health Users and Total Visits, by Number of Visits, FY 1996

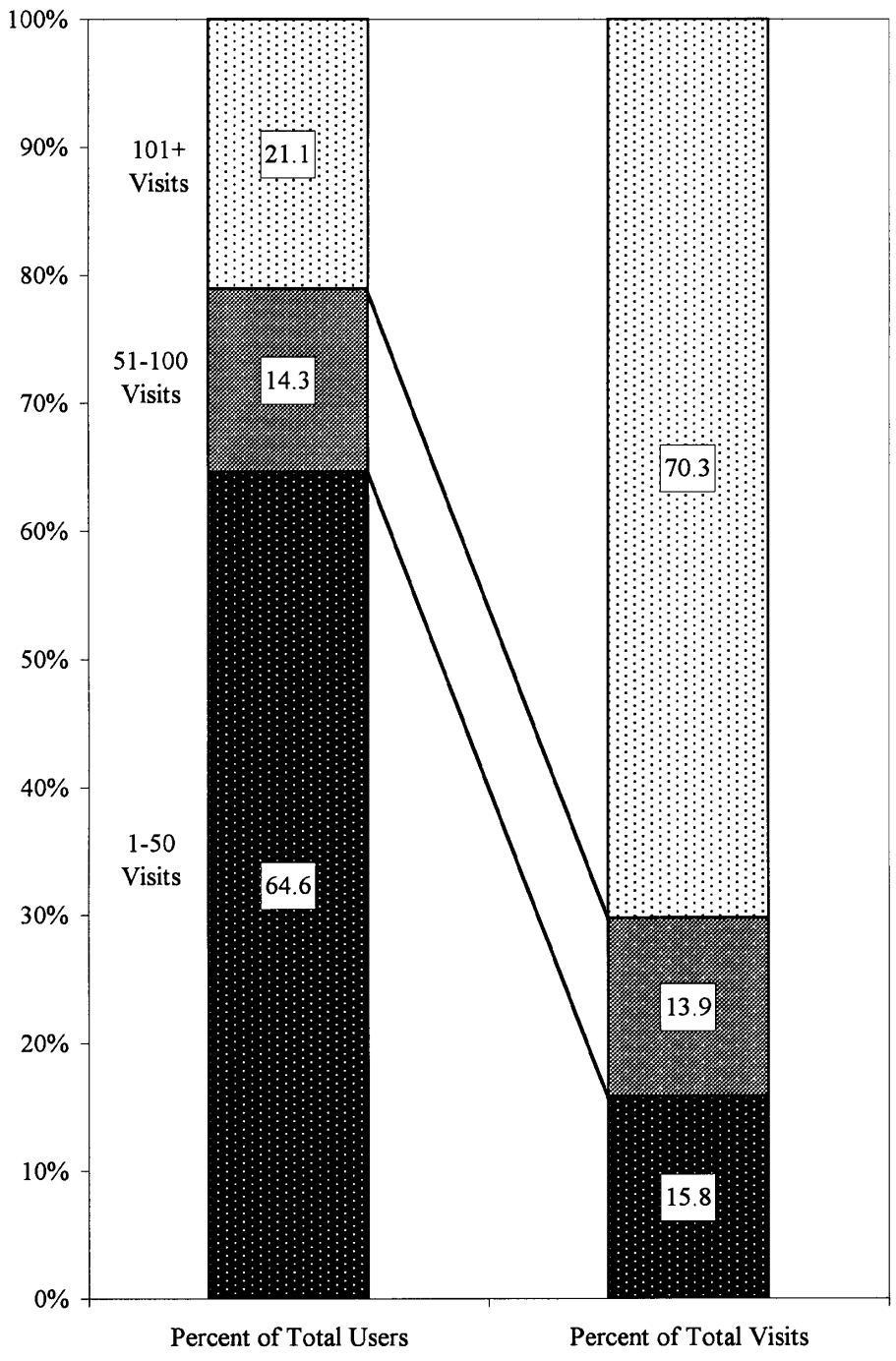
A large portion of the growth in volume of home health visits paid for by Medicare can be attributed to heavy users. By FY1996, home health users with more than 100 visits had grown to 21% of all users from 4% in 1988. In addition, these users accounted for the great bulk of covered home health visits—70% of all visits in FY1996 (see Figure 3.21). Persons receiving more than 300 visits accounted for 32% of all visits in that year but represented only 5% of users, as shown in the table below.

TABLE 3.21. Home Health Users and Total Visits, by Number of Visits, FY1996

Number of Visits per User	Number of Users	Share of Total Users (%)	Number of Visits	Share of Total Visits (%)
1–10	171,795	24.27	934,376	1.80
11–20	120,352	17.00	1,812,449	3.50
21–30	75,134	10.61	1,891,408	3.65
31–40	51,561	7.28	1,817,443	3.51
41–50	38,188	5.40	1,730,598	3.34
51–60	30,378	4.29	1,678,322	3.24
61–70	23,654	3.34	1,544,606	2.98
71–80	18,647	2.63	1,404,818	2.71
81–90	15,525	2.19	1,325,049	2.56
91–100	13,223	1.87	1,261,918	2.43
101–130 ..	31,244	4.41	3,581,118	6.91
131–160 ..	23,224	3.28	3,369,860	6.50
161–190 ..	20,061	2.83	3,507,514	6.77
191–220 ..	14,351	2.03	2,940,631	5.67
221–250 ..	10,699	1.51	2,513,069	4.85
251–280 ..	9,328	1.32	2,474,191	4.77
281–300 ..	5,018	0.71	1,455,632	2.81
300+	35,450	5.01	16,589,460	32.01
Total	707,832	100.00	51,832,462	100.00

Note: Table prepared by CRS.

Figure 3.21. Home Health Users and Total Visits, by Number of Visits, FY1996



Source: Figure prepared by CRS based on MedPAC analysis of a 20% sample of home health claims data provided by HCFA.

Figure 3.22.
Medicare Fee-for-Service Spending for Selected Service Categories, by Major Diagnostic Classifications, 1995

The table below shows Medicare fee-for-service spending by major diagnostic classification for four selected service categories: short stay hospital services, skilled nursing facility services, home health services, and physician and supplier services. Taken together, these four service categories accounted for 87.5 % of total Medicare fee-for-service payments for all diagnoses in 1995.

Over one-quarter of Medicare spending in 1995 in these selected service categories was for persons whose diagnosis was a disease of the circulatory system, primarily heart disease. Over 10% of spending was for persons whose diagnosis was a disease of the respiratory system, such as pneumonia and asthma. The categories of neoplasms (cancers), and injury and poisonings, each constituted close to 9% of spending. Other disease categories represented a smaller proportion of the total. For example, endocrine, nutritional and metabolic diseases (including diabetes) jointly represented under 5% of the total.

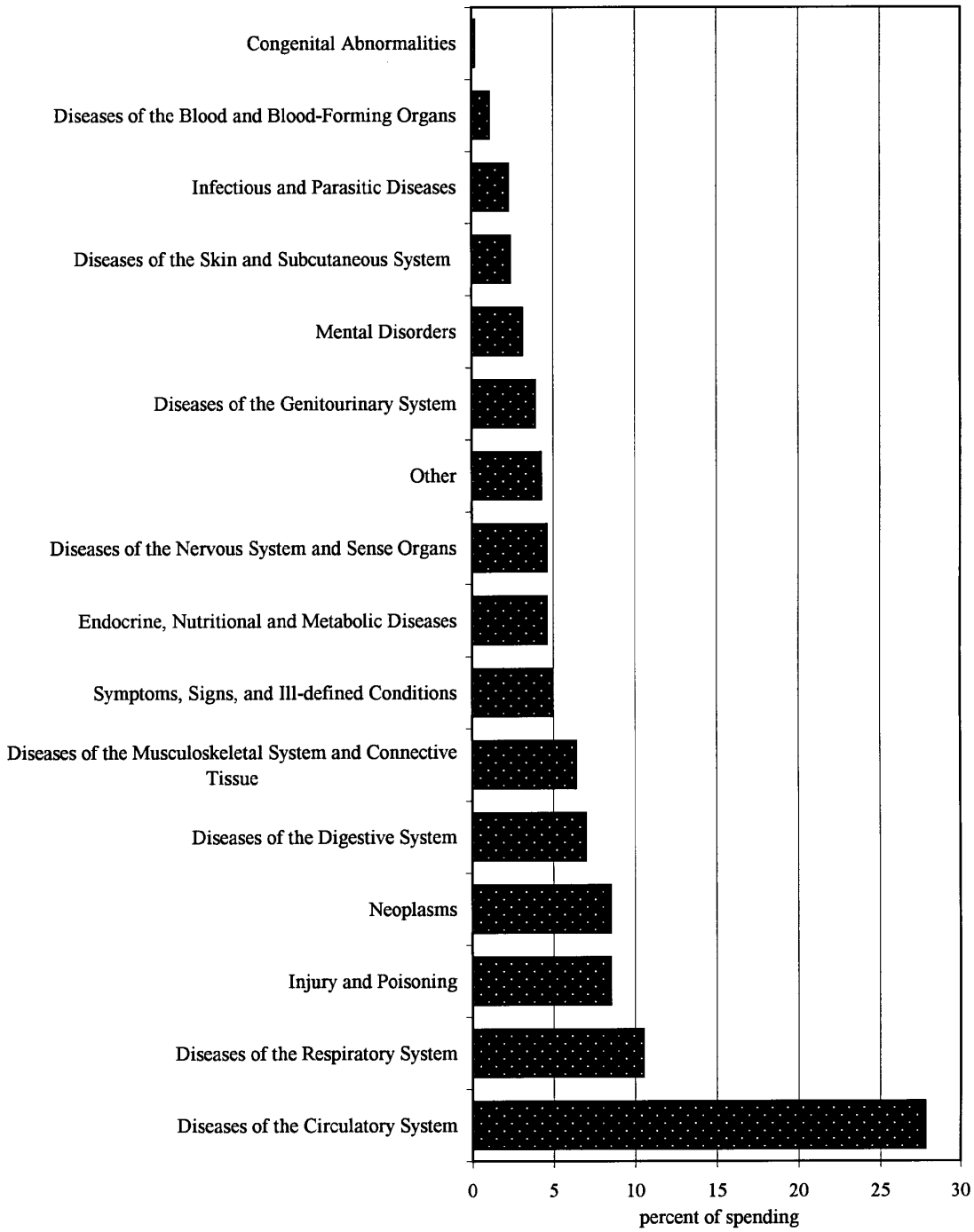
TABLE 3.22. Medicare Spending for Selected Service Categories, by Major Diagnostic Classifications, 1995

(in thousands)

Major Diagnostic Classifications	Spending	Percent of Grand Total
Congenital abnormalities	$ 242,693	0.2%
Diseases of the blood and blood-forming organs	1,483,755	1.1%
Infectious and parasitic diseases	3,234,879	2.3%
Diseases of the skin and subcutaneous system	3,411,521	2.4%
Mental disorders	4,273,033	3.1%
Diseases of the genitourinary system	5,501,940	3.9%
Other	6,031,643	4.3%
Diseases of the nervous system and sense organs	6,410,261	4.6%
Endocrine, nutritional and metabolic diseases	6,500,646	4.6%
Symptoms, signs, and ill-defined conditions	6,917,179	4.9%
Diseases of the musculoskeletal system and connective tissue	8,945,088	6.4%
Diseases of the digestive system	9,800,807	7.0%
Neoplasms	11,836,200	8.5%
Injury and poisoning	11,870,067	8.5%
Diseases of the respiratory system	14,640,590	10.5%
Diseases of the circulatory system	38,893,001	27.8%
Total, all diagnoses	$139,993,303	100.0%

Note: Includes Medicare fee-for-service spending for short-stay hospital services, skilled nursing facility services, home health services, and services provided by physicians and suppliers. Together, these accounted for 87.5% of Medicare fee-for-service payments in CY1995. Table prepared by CRS.

Figure 3.22. Medicare Fee-for-Service Spending for Selected Service Categories, by Major Diagnostic Classifications, 1995



Source: Figure prepared by CRS based on HCFA, *Medicare and Medicaid Statistical Supplement*, 1997. See note in table 3.22.

Figure 3.23.
Average Per Capita Medicare Spending, FY1999–FY2009

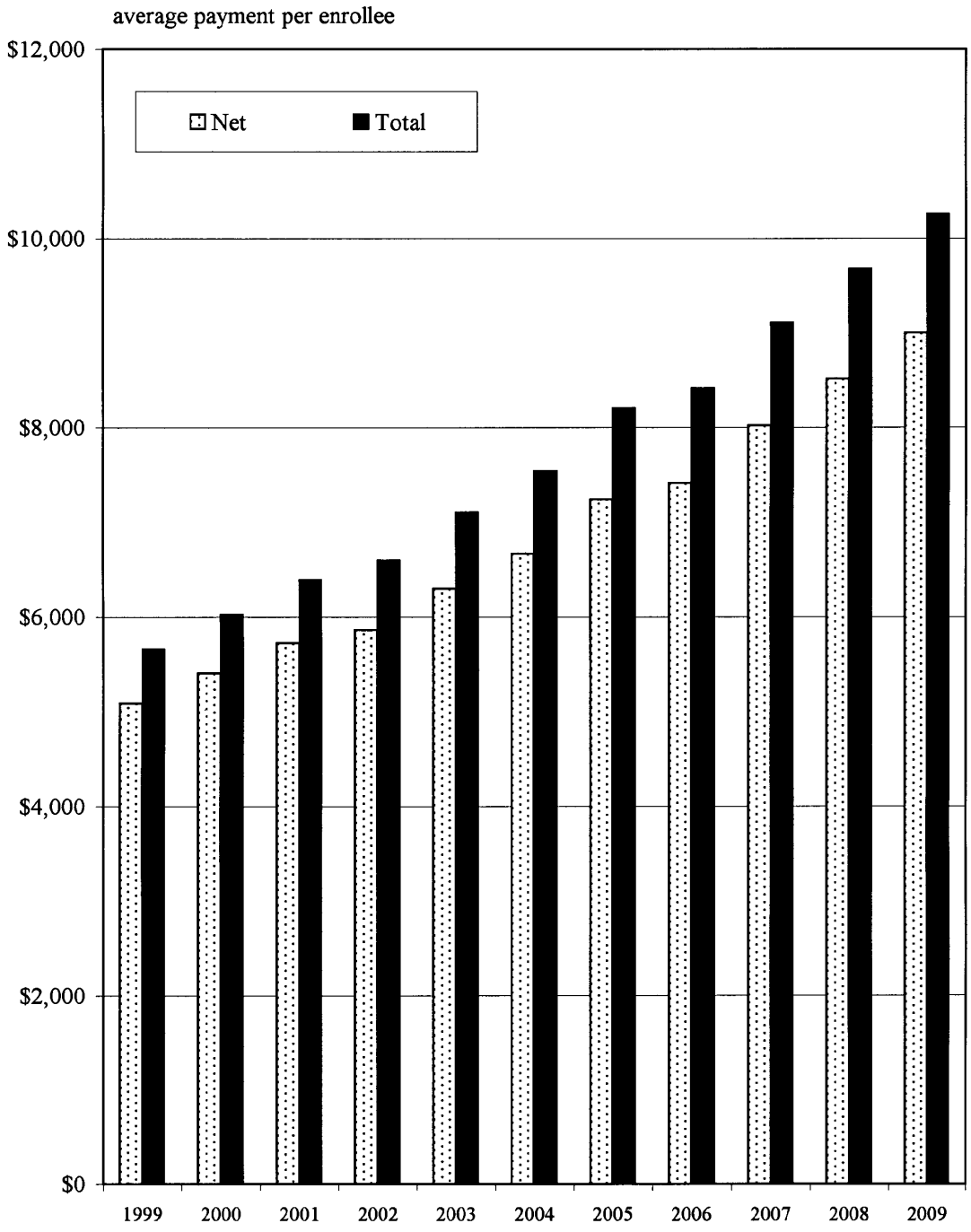
Total per capita Medicare spending per enrollee (including administrative costs) is expected to increase from $5,657 in FY1999 to $10,257 in FY2009, for an average annual rate of increase of 6.1% over the period. Net per capita spending (after deduction of beneficiary premiums) is expected to increase from $5,089 to $8,999, for an average annual rate of increase of 5.8%

TABLE 3.23. Average Per Capita Medicare Spending, FY1999–FY2009

	Total	Net
1999	5,657	5,089
2000	6,025	5,408
2001	6,387	5,722
2002	6,597	5,861
2003	7,105	6,299
2004	7,541	6,666
2005	8,204	7,238
2006	8,414	7,413
2007	9,110	8,024
2008	9,677	8,516
2009	10,257	8,999

Note: Totals may not add due to rounding Table prepared by CRS.

Figure 3.23. Average Per Capita Medicare Spending, FY1999-FY2009



Source: Figure prepared by CRS based on CBO projections (March 1999).

Figure 3.24.
Distribution of Medicare Spending for Beneficiaries, 1995

Medicare spending is unevenly distributed among beneficiaries. In 1995, 5% of elderly beneficiaries accounted for 45% of Medicare spending for this population group. Only 14% of beneficiaries accounted for close to three-fourths (73%) of all spendings for elderly beneficiaries. Clearly, in a given year, the majority of health costs are concentrated among a minority of persons.

A similar and even more pronounced pattern is reflected in Medicare spending for disabled beneficiaries. In 1995, 7% of disabled beneficiaries accounted for over one-half (56%) of this group's total spending for the year, and 15% accounted for over three-quarters (79%) of spending.

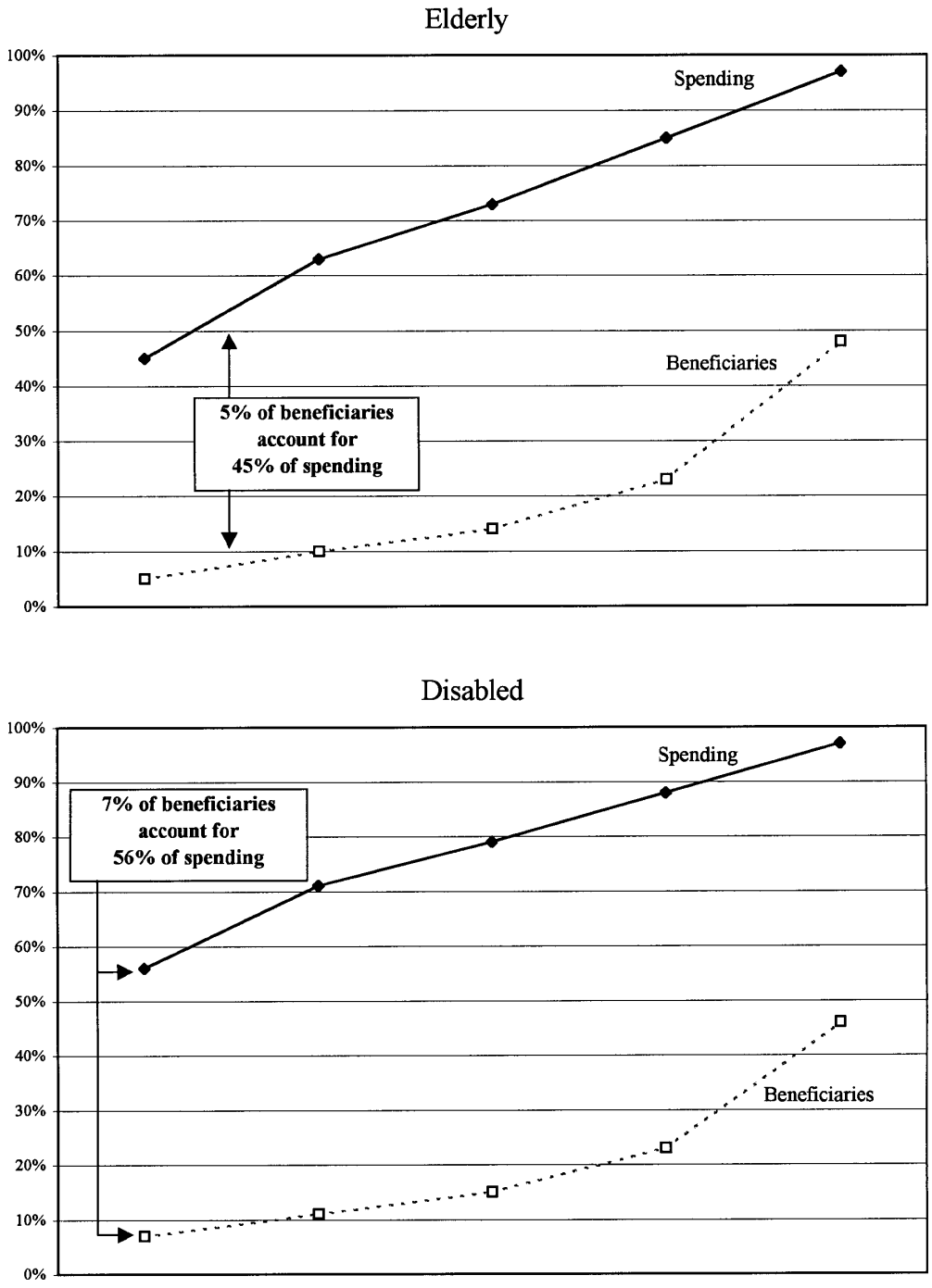
TABLE 3.24. Distribution of Medicare Spending for Beneficiaries, 1995

(in percent)

Elderly		Disabled	
Percent of Beneficiaries	Percent of Spending	Percent of Beneficiaries	Percent of Spending
5	45	7	56
10	63	11	71
14	73	15	79
23	85	23	88
48	97	46	97

Note: Table prepared by CRS.

Figure 3.24. Distribution of Medicare Spending for Beneficiaries, 1995



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996.*

Figure 3.25.
Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee, by Age, 1995

The average annual benefit payment per Medicare elderly enrollee increases by age, reflecting the need for more health care as this population ages. In 1995, the average Part A payment was $1,519 for the 65 to 66 year old population, rising to $4,634 for those 85 and older. Similarly, Part B payments increased from $1,154 for the youngest age group to $1,869 for the oldest group.

TABLE 3.25. Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee, by Age, 1995

	Part A	Part B
65 and 66 years	$1,519	$1,154
67 and 68 years	1,755	1,278
69 and 70 years	1,978	1,351
71 and 72 years	2,219	1,450
73 and 74 years	2,521	1,566
75–79 years	2,982	1,705
80–84 years	3,848	1,839
85+ years	4,634	1,869

Note: Table prepared by CRS.

Figure 3.25. Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee, by Age, 1995

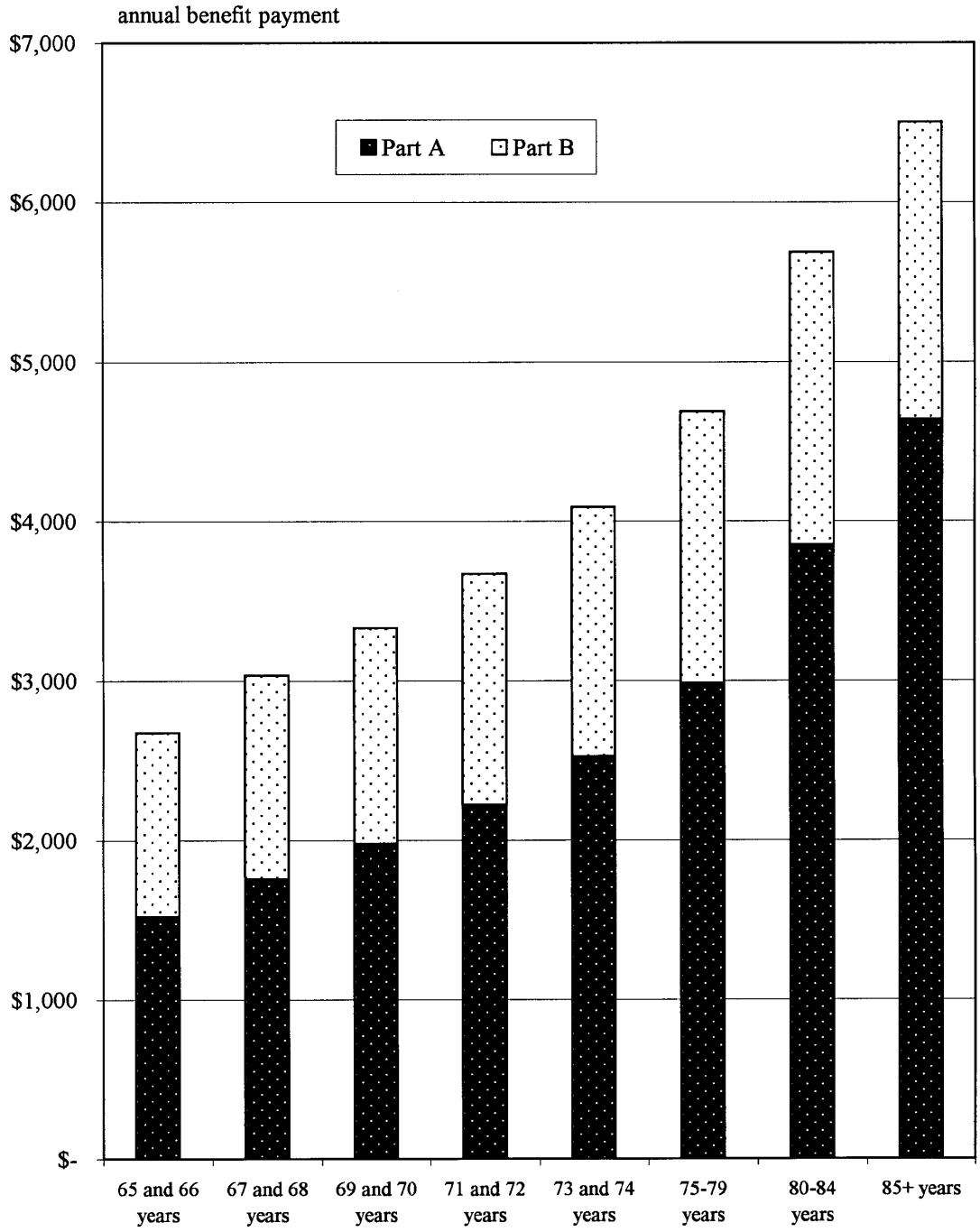


Figure prepared by CRS based on HCFA, unpublished data.

Figure 3.26.
Average Medicare Benefit Payment Per User of Services by Mortality, ESRD, and Hospital Status, 1995

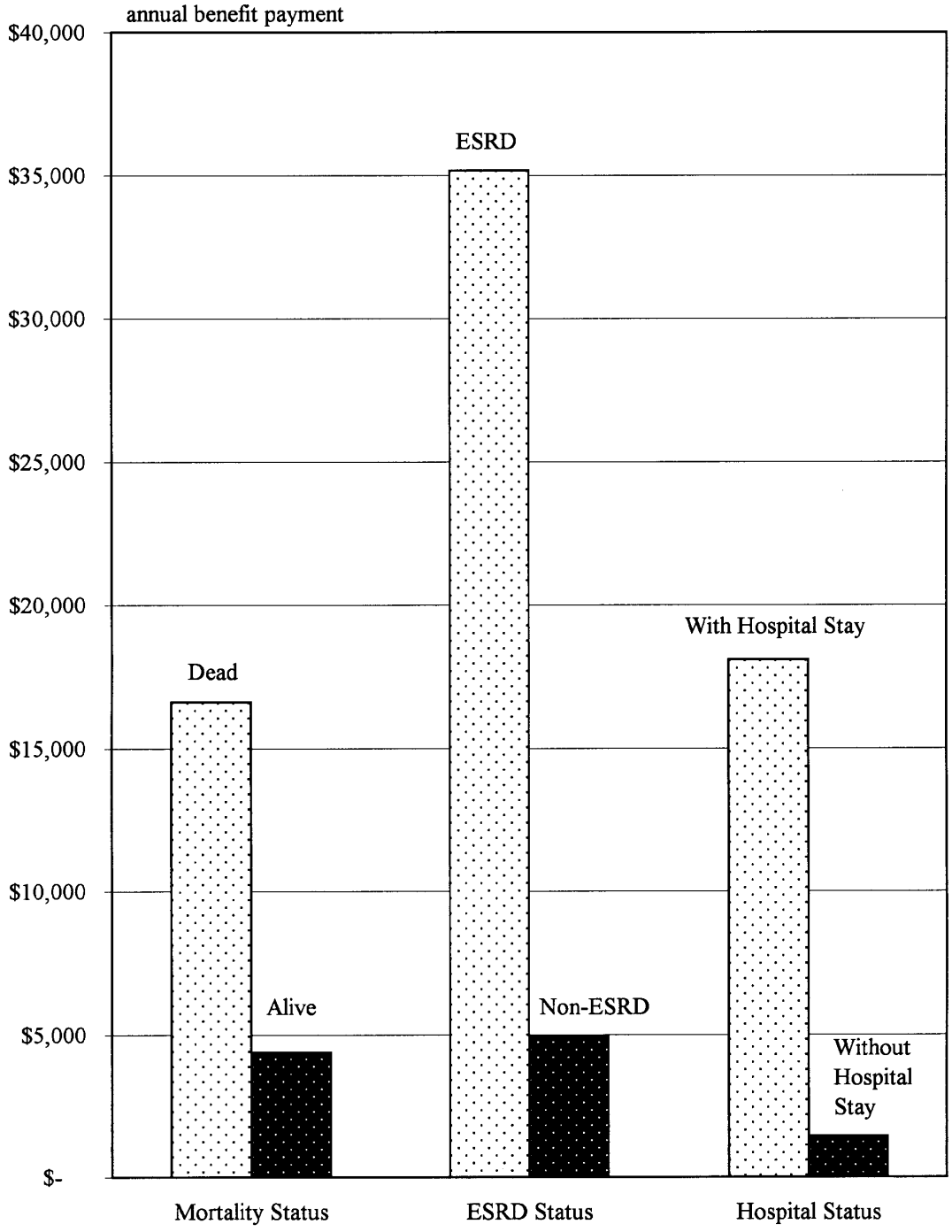
High Medicare spending is frequently associated with specific beneficiary characteristics, namely, whether the person died during the year, whether they were ESRD beneficiaries, or whether they had a hospital stay. In 1995, the average program payment per person for those who died during the year was $16,613, compared to $4,383 for persons who used services but remained alive during the year. In the same year, ESRD beneficiaries averaged $35,154 in payments while non-ESRD beneficiaries who used services averaged $4,963. Persons using hospital services also had higher costs—$18,080 per person compared to $1,437 for users without a hospital stay. The average payment for all users of services was $5,226 in 1995.

TABLE 3.26. Average Medicare Benefit Payment Per User of Services by Mortality, ESRD, and Hospital Status, 1995

Type of Service User	Average Benefit Payment
Mortality status: dead	$16,613
Mortality status: alive	4,383
ESRD	35,154
Non-ESRD	4,963
With hospital stay	18,080
Without hospital stay	1,437

Note: Excludes persons for whom no Medicare payments were made during the year. Table prepared by CRS.

Figure 3.26. Average Medicare Benefit Payment Per User of Services by Mortality, ESRD, and Hospital Status, 1995



Source: Figure prepared by CRS based on *HCFA: Medicare and Medicaid Statiscal Supplement*, 1997. See note in Table 3.26.

Figure 3.27.
Average Medicare Payments Per Enrollee by State and by Region, CY1996

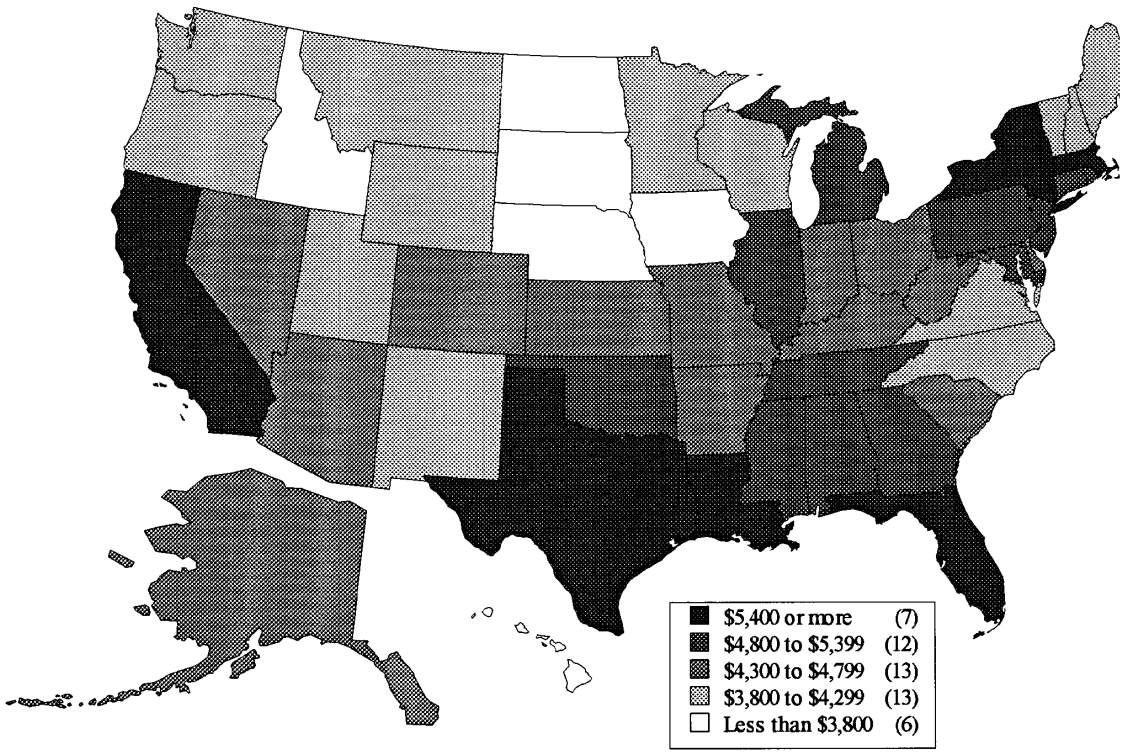
The average Medicare payment per beneficiary varies by state and by geographic region. In 1996, six States had per enrollee payments over $5,400—Louisiana ($6,553), Massachusetts ($6,266), California ($5,986), Florida ($5,901), Texas ($5,905), and New York ($5,541). The District of Columbia recorded a per enrollee payment of $6,631 for the same period. The lowest per capita payment was recorded in Nebraska ($3,512). The average payment also varied by geographic region, ranging from $4,069 in the West North Central region to $5,709 in the West South Central Division.

TABLE 3.27. Average Medicare Payments Per Enrollee by Region and Subregion, CY1996

	Dollars Per Enrollee
United States	$5,048
Region	
Northeast	5,427
Midwest	4,492
South	5,225
West	5,032
Subregion	
New England	5,418
Middle Atlantic	5,430
East North Central	4,675
West North Central	4,069
South Atlantic	5,045
East South Central	5,031
West South Central	5,709
Mountain	4,299
Pacific	5,379

Note: Table prepared by CRS.

Figure 3.27. Average Medicare Payments Per Enrollee by State and by Region, CY1996



Source: Map prepared by CRS based on HCFA, *Medicare and Medicaid Statistical Supplement, 1998.*

Figure 3.28.
Trends in Medicare Part A and Part B Administrative Expenses, 1970–1997

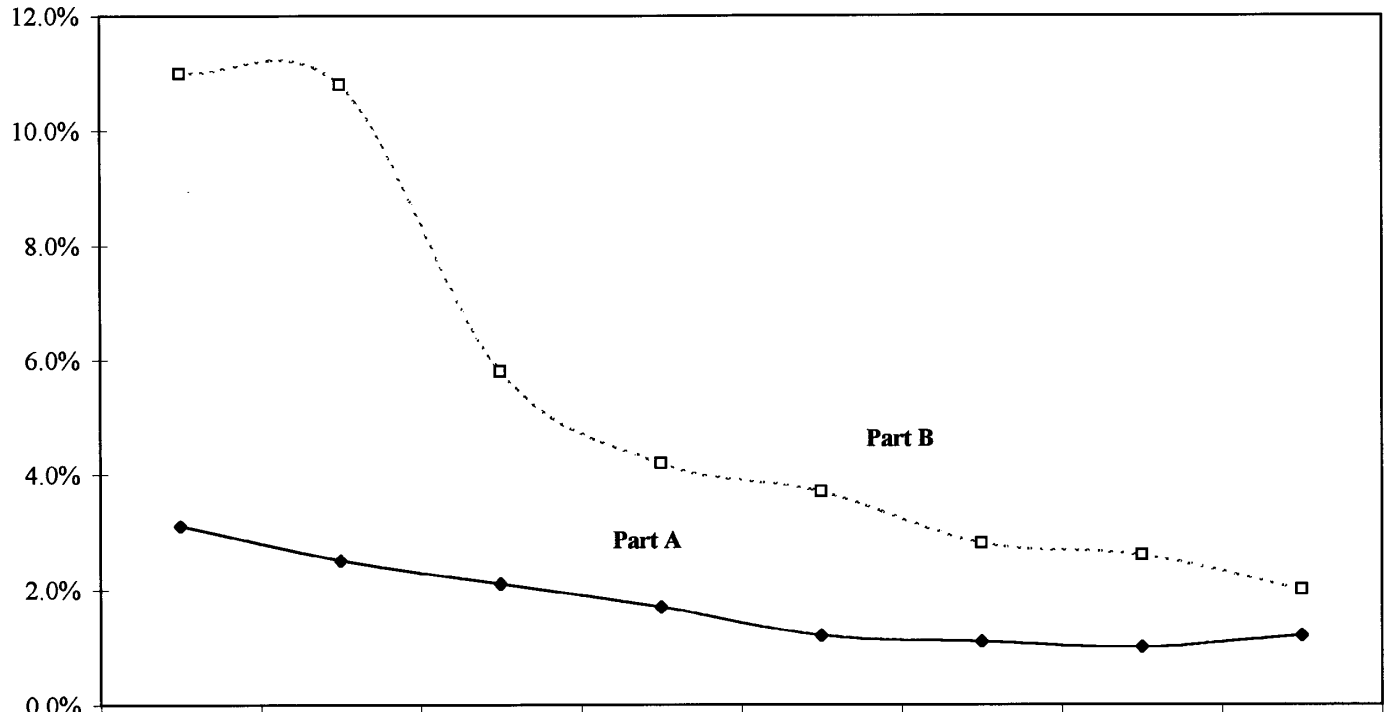
Medicare administrative costs are a small and declining portion of total benefit payments. In 1970, administrative costs represented 3.1% of Part A benefit payments and 11% of Part B benefit payments. By 1997, administrative costs had dropped to 1.2 % of Part A payments and 2.0% of Part B payments. This reflects, in part, technological improvements in automated claims processing. Over 96% of hospital and skilled nursing facility claims are submitted electronically and 79% of physician, laboratory and durable medical equipment claims are submitted electronically.

TABLE 3.28. Trends in Medicare Part A and Part B Administrative Expenses (as a percent of Part A and Part B benefit payments), 1970–1997

Year	Part A	Part B
1970	3.1	11.0
1975	2.5	10.8
1980	2.1	5.8
1985	1.7	4.2
1990	1.2	3.7
1992	1.5	3.4
1993	1.0	3.5
1994	1.2	3.0
1995	1.1	2.8
1996	1.0	2.6
1997	1.2	2.0

Note: Table prepared by CRS.

Figure 3.28. Trends in Medicare Part A and Part B Administrative Expenses, 1970-1997



	1970	1975	1980	1985	1990	1995	1996	1997
Part A	3.1%	2.5%	2.1%	1.7%	1.2%	1.1%	1.0%	1.2%
Part B	11.0%	10.8%	5.8%	4.2%	3.7%	2.8%	2.6%	2.0%

Source: Figure prepared by CRS based on HCFA, *1998 HCFA Data Compendium.*

Figure 3.29.
Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993

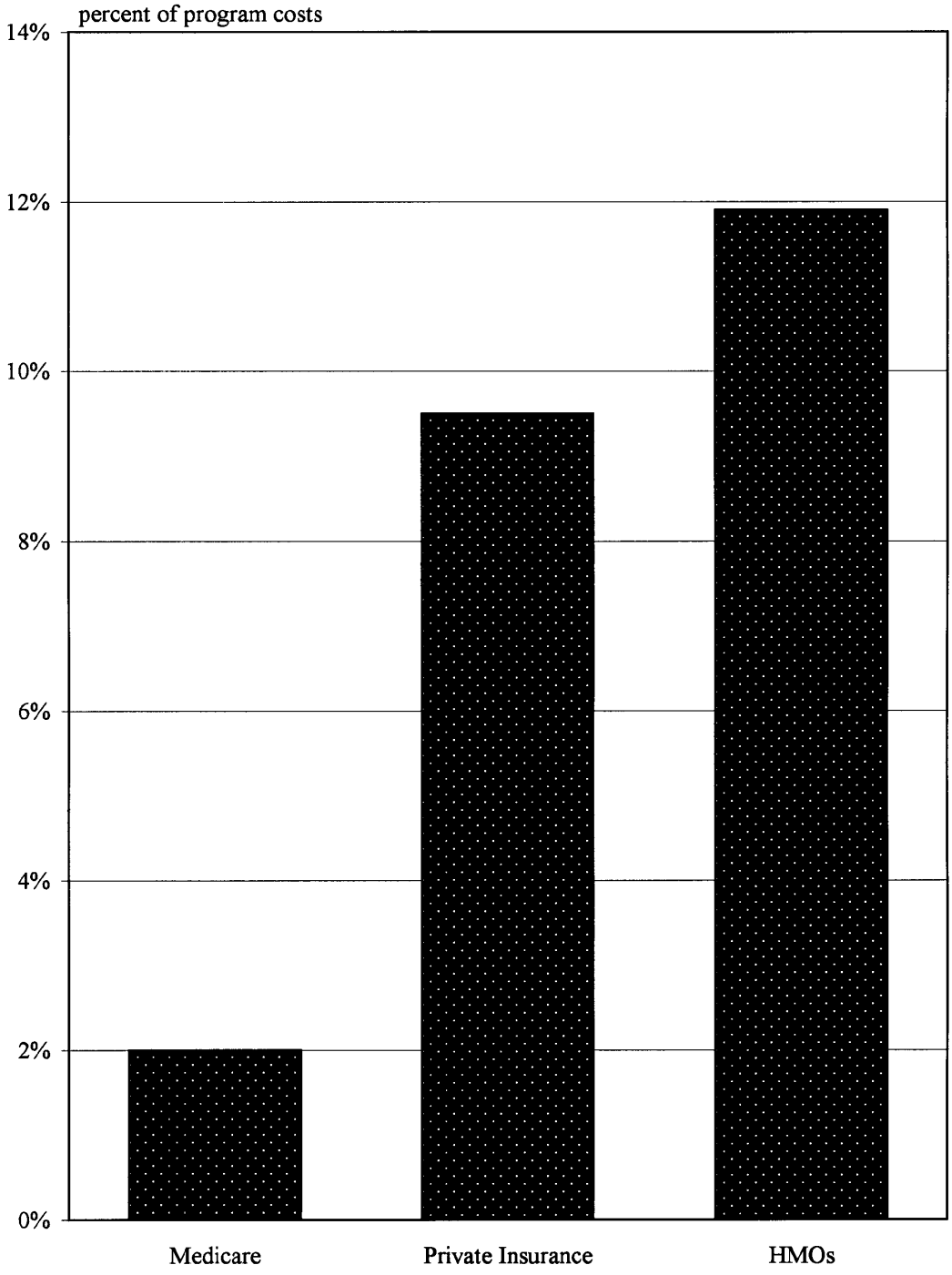
Medicare's administrative costs are substantially lower than those for private insurance. In 1993, Medicare's administrative costs represented about 2% of total program costs, while such costs represented 9.5% of private insurers costs and 11.9% of program costs for health maintenance organizations (HMOs). Private insurance and HMO administrative costs include marketing, profits, and other costs which are not part of Medicare's expenses. Administrative costs for HMOs are higher than for private insurance because HMOs invest more resources into managing the care provided to enrollees.

TABLE 3.29. Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993

	Percent of Costs
Medicare	2.0
Private insurance	9.5
HMOs	11.9

Note: Table prepared by CRS.

Figure 3.29. Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare*, 1996.

Figure 3.30.
Trends in Medicare Claims Volume, 1970–1997

The volume of Medicare claims rose from 60.9 million in 1970 to an estimated 842.7 million in 1997. This is close to a thirteen-fold increase. Growth has been greater for Part B claims than for Part A claims.

The rapid rise in the volume of claims reflects a number of factors, including increased utilization due to the growing number of beneficiaries, the increasing longevity of the beneficiary population, and advances in medical technology. The higher increase in the number of Part B claims reflects the fact that Part B claims continue to be based on small units of services (e.g., a lab test), while Part A claims now generally represent a larger unit of service, e.g., a hospital admission. The increase in Part B claims also reflects the addition of several service categories, e.g., preventive screenings and flu shots.

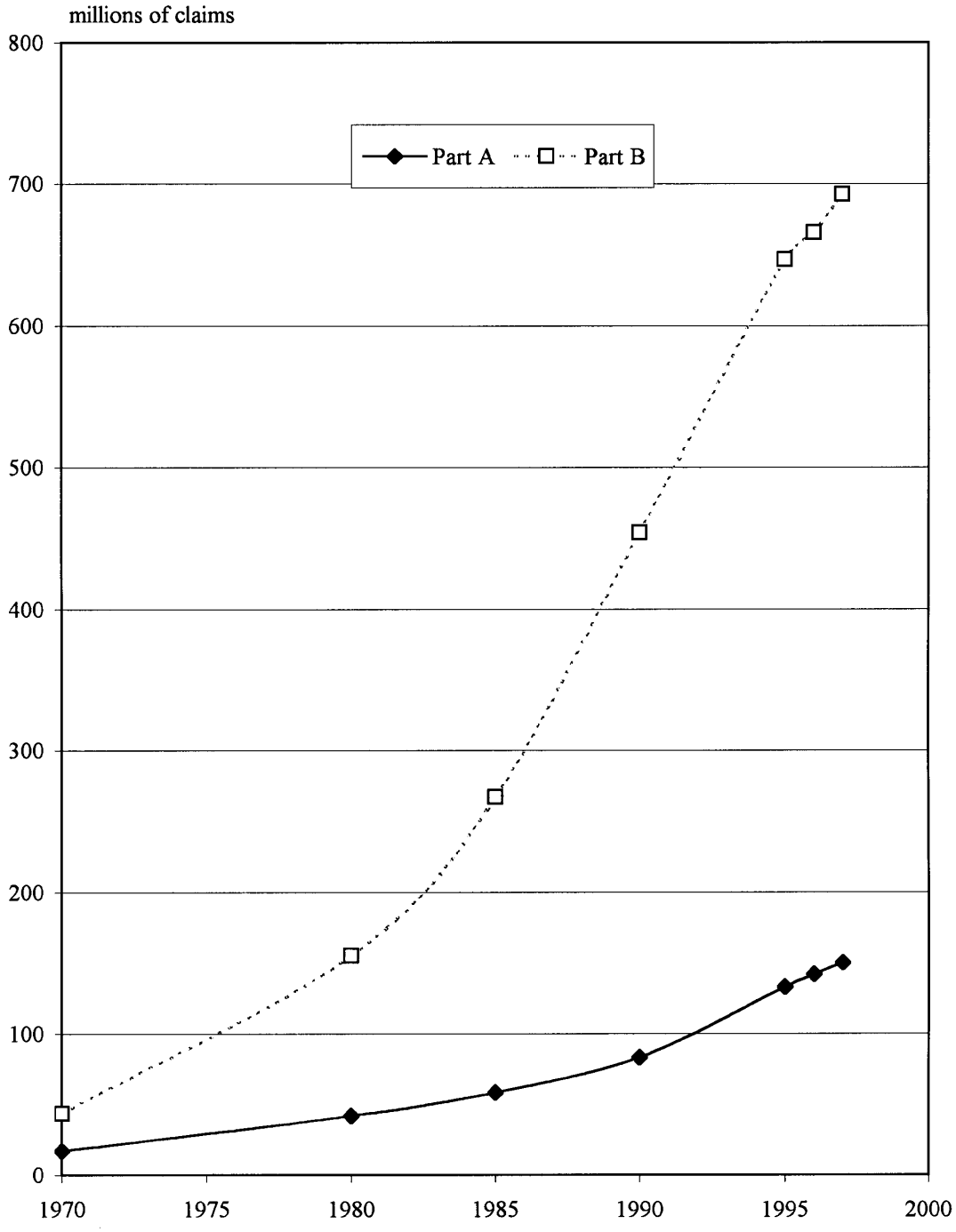
TABLE 3.30. Trends in Medicare Claims Volume, 1970–1997

(in millions)

Year	Part A Claims	Part B Claims	Total Claims
1970	17.1	43.8	60.9
1980	41.8	155.0	196.8
1985	58.5	267.2	325.8
1990	83.2	453.9	537.1
1995	133.1	646.5	779.6
1996	142.1	665.6	807.7
1997	150.0	692.7	842.7

Note: Table prepared by CRS.

Figure 3.30. Trends in Medicare Claims Volume, 1970-1997



Source: Figure prepared by CRS, based on HCFA, *Justification of Estimates for Appropriations Committees, Selected Years.*

Figure 3.31.
Medicare Part A Trust Fund: Income and Outlays, FY1970–FY2009

Income to the Medicare Part A Hospital Insurance Trust Fund traditionally exceeded outlays. However, beginning in FY1995, this pattern was reversed. In that year, the program paid out $36 million more than it took in. The difference totaled $4.2 billion in FY1996 and $9.3 billion in 1997. BBA 97 reduced the rate of growth in Medicare spending. It also shifted some spending from Part A to Part B. As a result, both CBO and the Administration estimate that income will exceed outgo through 2006.

TABLE 3.31. Medicare Part A Trust Fund: Income and Outlays, FY1970–FY2009

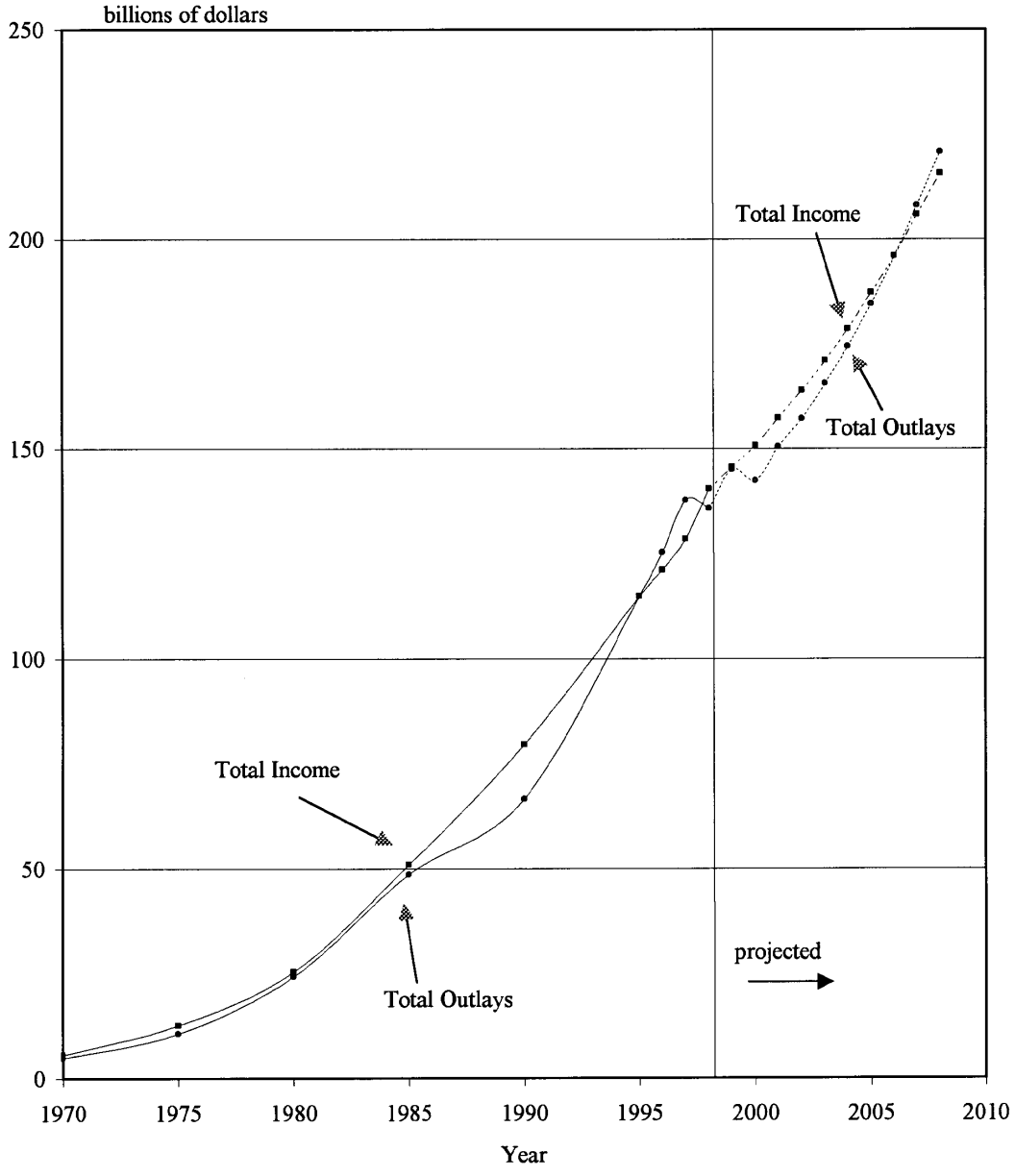
(in billions)

Year	Total Income	Total Outlays
1970	$5.6	$5.0
1975	12.6	10.6
1980	25.4	24.3
1985	50.9	48.7
1990	79.6	66.7
1995	114.9	114.9
1996	121.1	125.3
1997	128.5	137.8

Projections	Administration	CBO	Administration	CBO
1998	140.5	138.2	135.8	136.3
1999	145.7	145.4	145.2	135.0
2000	150.8	150.9	142.5	141.1
2001	157.3	154.7	150.6	147.1
2002	163.9	163.7	157.2	150.6
2003	171.0	171.0	165.6	160.9
2004	178.6	178.9	174.4	171.0
2005	187.3	188.0	184.6	185.7
2006	196.1	196.3	196.0	193.1
2007	205.9	205.1	208.1	210.4
2008	215.7	213.4	220.8	226.3
2009	N.A.	221.5	N.A.	242.9

Note: Table prepared by CRS.

Figure 3.31. Medicare Part A Trust Fund: Income and Outlays, FY1970-FY2009



Source: Prepared by CRS based on *1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, (1970-99).

Figure 3.32.
Medicare Part A Trust Fund: End-of-Year Balance, FY1970–FY2009

The balance in the Part A Hospital Insurance Trust Fund is currently increasing. The end-of-year balance began to drop in FY1995. Prior to enactment of BBA 97, both the CBO and the Medicare trustees estimated that the balance would fall below zero in FY2001. However, with passage of this legislation, both CBO and the Medicare trustees estimate that the balance will continue to rise through 2006. In March 1999, the Medicare trustees projected the fund would become insolvent in 2015.

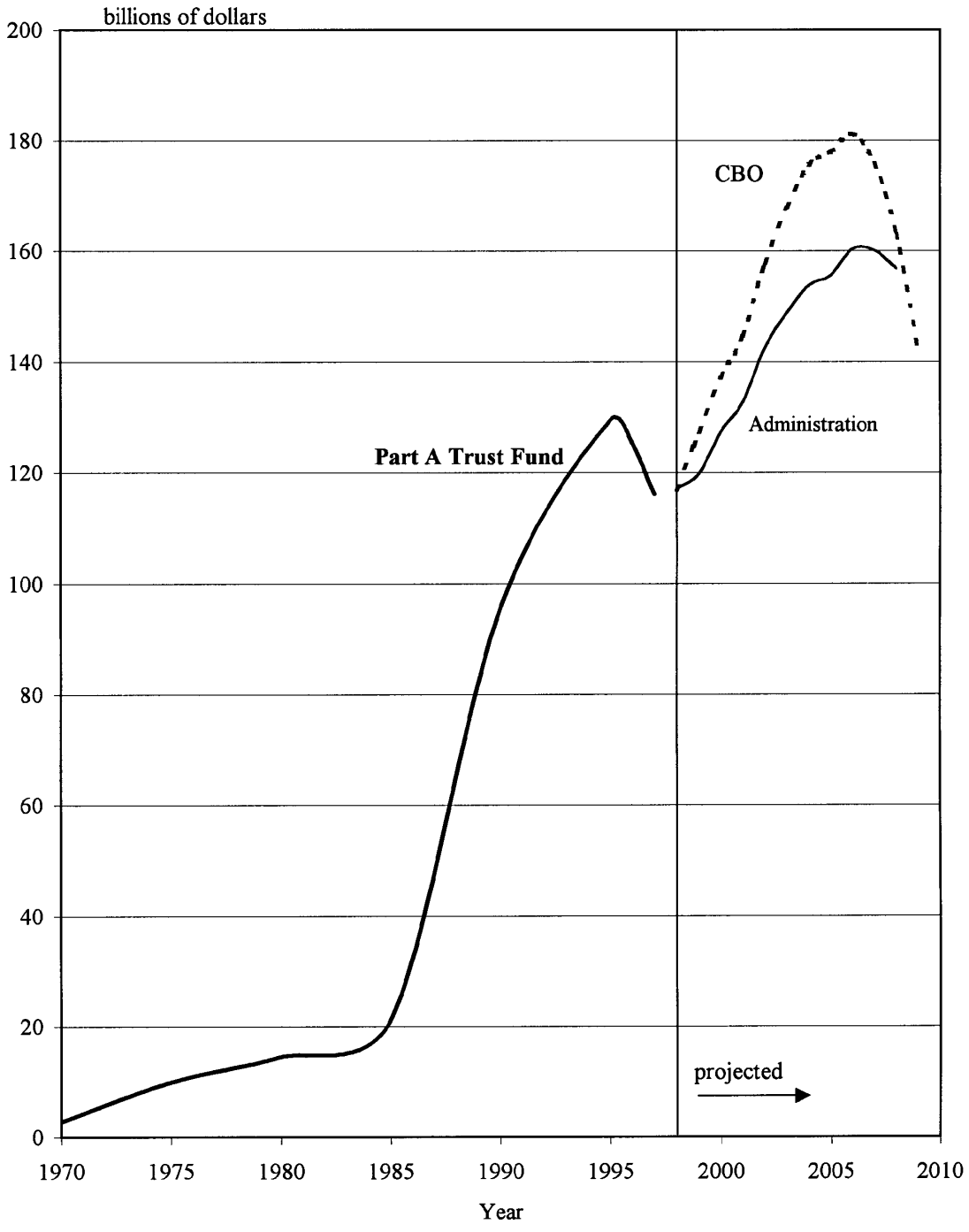
TABLE 3.32. Medicare Part A Trust Fund: End-of-Year Balance, FY1970–FY2009

(in billions)

Year	End-of-Year Balance	
1970	$2.7	
1975	9.9	
1980	14.5	
1985	21.3	
1990	95.6	
1995	129.5	
1996	125.3	
1997	116.1	
Projections	**Administration**	**CBO**
1998	117.1	116.9
1999	119.8	127.3
2000	127.4	137.1
2001	132.8	144.6
2002	142.5	157.7
2003	148.9	167.8
2004	153.8	175.6
2005	155.6	177.9
2006	160.4	181.1
2007	160.1	175.8
2008	156.8	163.0
2009	N.A.	141.6

Note: Table prepared by CRS

Figure 3.32. Medicare Part A Trust Fund: End-of-Year Balance, FY1970-FY2009



Source: Prepared by CRS based on *1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*; and CBO, March 1999 baseline (1998-2009).

Figure 3.33.
Medicare Part A Trust Fund:
Projected Income and Cost Rates, 1999–2070

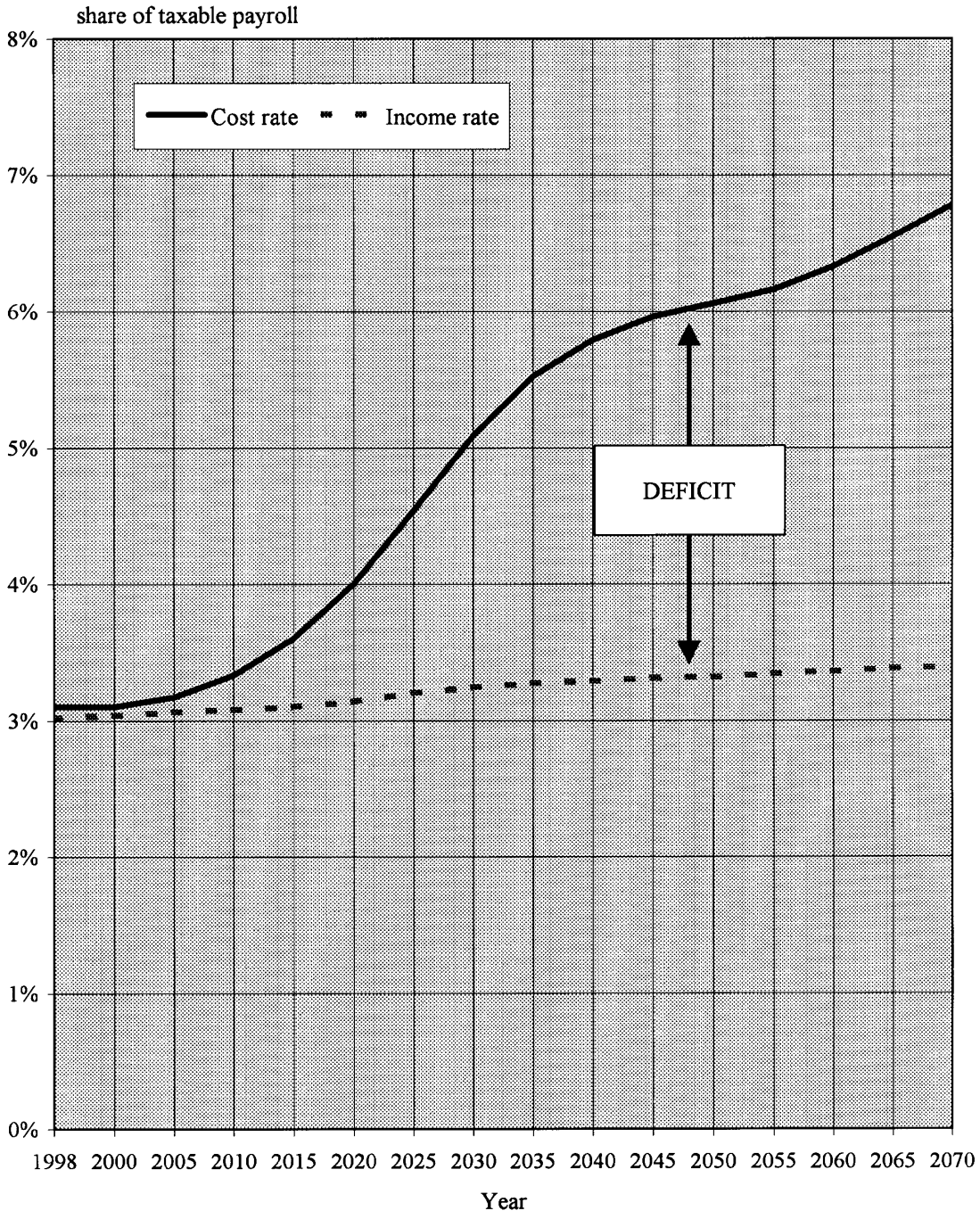
The Medicare trustees measure long-range financial soundness of the hospital insurance (HI) trust fund by comparing: (1) HI tax income (payroll tax and income from taxation of a portion of Social Security benefits) as a percentage of taxable payroll ("income rate") with (2) HI cost as a percentage of taxable payroll ("cost rate"). The trustees view this measure as more meaningful since the value of the dollar changes over time. There is already a gap between the cost rate and the income rate. The 1999 estimated cost rate is 3.10% of taxable payroll, whereas the estimated income rate is 3.02%. The gap is thus 0.08% of taxable payroll. Since costs are rising faster than payroll tax receipts, the deficit increases over the projection period, rising to 0.26 percentage points in 2010 and to 3.39 percentage points by 2070. This represents an improvement over the 1997 and 1998 projections.

TABLE 3.33. Medicare Part A Trust Fund:
Projected Income and Cost Rates, 1999–2070

Calendar Year	Income Rate (in percent)	Cost Rate (in percent)	Difference Between Income Rate and Cost Rate
1999	3.02	3.10	−0.08
2000	3.04	3.10	−0.05
2005	3.06	3.17	−0.11
2010	3.08	3.33	−0.26
2015	3.10	3.60	−0.50
2020	3.14	4.00	−0.86
2025	3.20	4.54	−1.35
2030	3.24	5.09	−1.85
2035	3.27	5.52	−2.24
2040	3.29	5.79	−2.50
2045	3.31	5.96	−2.65
2050	3.32	6.06	−2.74
2055	3.34	6.16	−2.82
2060	3.36	6.33	−2.97
2065	3.38	6.55	−3.17
2070	3.39	6.78	−3.39

Note: Data for 1999–2070 are projections made by the trustees of the Hospital Insurance Trust Fund.

Figure 3.33. Medicare Part A Trust Fund: Projected Income and Cost Rates, 1999-2070



Source: Figure prepared by CRS based on HHS, *1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.*

Figure 3.34.
Incurred Medicare Outlays and Social Security Outlays, Calendar Years 1999–2030

Traditionally, spending on Social Security (i.e., the Old Age, Survivors, and Disability Insurance (OASDI) programs)), has been the largest social welfare expenditure in the federal budget. Medicare has been second. Prior to enactment of BBA 97, Medicare spending (calculated on the basis of obligations incurred, rather than cash outlays) was expected to outpace Social Security spending beginning in 2022. However, BBA 97 cut the long-term Medicare deficit in half. As a result, the trustees estimate that Social Security spending will continue as the largest social welfare program through at least the entire projection period (i.e., through 2072). Despite this fact, the rate of growth in spending on Medicare will exceed the rate of growth in Social Security cash payments. Projected Medicare growth reflects medical care inflation, changes in the mix and utilization of services, and the aging of the population (particularly among the oldest group).

Both Medicare and Social Security are expected to consume an expanding share of the nation's economy. In 1999, Medicare spending ($225.3 billion) will be an estimated 2.6% of the gross domestic product (GDP), while Social Security and Medicare together ($619.3 billion) will represent 7.0% of GDP. Medicare is projected to grow to $450.8 billion (3.0% of GDP) in 2010, while the two programs together will total $1.2 trillion (7.8% of GDP). By 2030, Medicare is expected to grow to $1.8 trillion and its share of GDP is expected to climb to 4.9%. Medicare and Social Security together ($4.4 trillion) would climb to 11.7% of GDP.

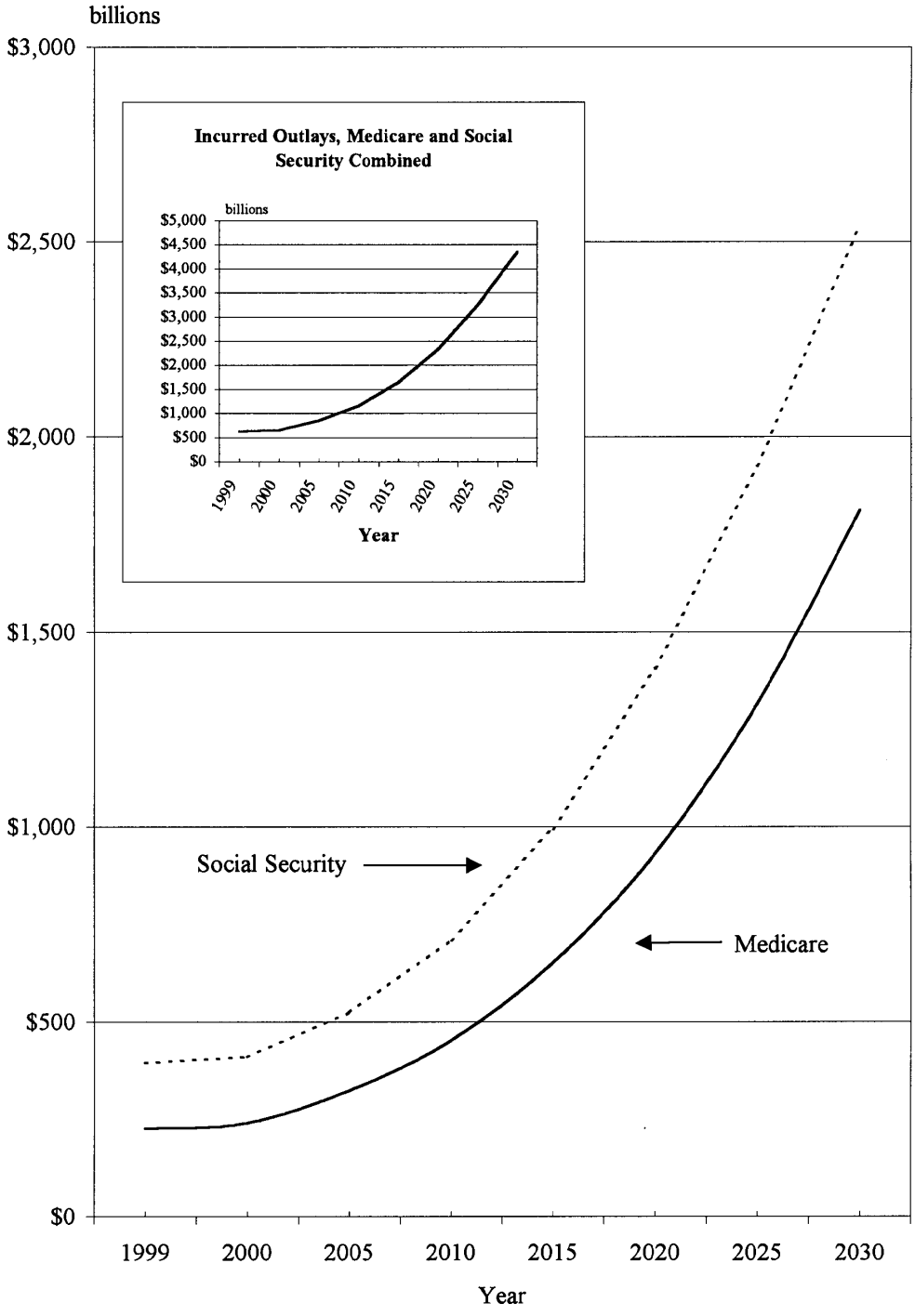
TABLE 3.34. Incurred Medicare Outlays and Social Security Outlays, Calendar Years 1999–2030

(in billions)

Calendar Year	HI Total Incurred Outgo	SMI Total Incurred Outgo	Medicare Total	Social Security	Medicare Plus Social Security
1999	138.4	86.9	225.3	394.0	619.3
2000	143.3	96.3	239.6	409.0	648.6
2005	182.9	139.3	322.2	524.0	846.2
2010	245.8	205.0	450.8	710.0	1160.8
2015	334.6	316.8	651.4	995.0	1646.4
2020	463.8	467.0	930.8	1405.0	2335.8
2025	653.0	661.2	1314.1	1925.0	3239.1
2030	907.6	904.3	1811.9	2542.0	4353.9

Note: Table prepared by CRS; totals may not add due to rounding.

Figure 3.34. Incurred Medicare Outlays and Social Security Outlays, Calendar Years 1999-2030



Source: Prepared by CRS based on data from 1999 HI, SMI, and OASDI Trustees' Report (and accompanying tables).

Figure 3.35.
Hospital Insurance Cumulative Shortfall, Calendar Years 1999–2030

In calendar year 1999, estimated income to the Hospital Insurance trust fund will be an estimated $134.7 billion; however, incurred expenditures from the trust fund will be an estimated $138.4 billion. This leaves a shortfall of $3.7 billion in 1999. Over time the estimated yearly shortfall increases rapidly, rising to $19.0 billion in 2010, $99.2 billion in 2020, and $329.7 billion by 2030. The cumulative shortfall for the calendar year 1999–2030 period is estimated at close to $2.8 trillion. (The income and outgo numbers differ from the trust fund numbers shown in the previous tables. These estimates somewhat understate income to the trust fund because they exclude premiums paid by the small number of persons who obtain Part A coverage by paying a monthly premium; the income figures also exclude interest. Both the income and outgo figures reflect obligations incurred during the calendar year, rather than cash outlays made during the period.)

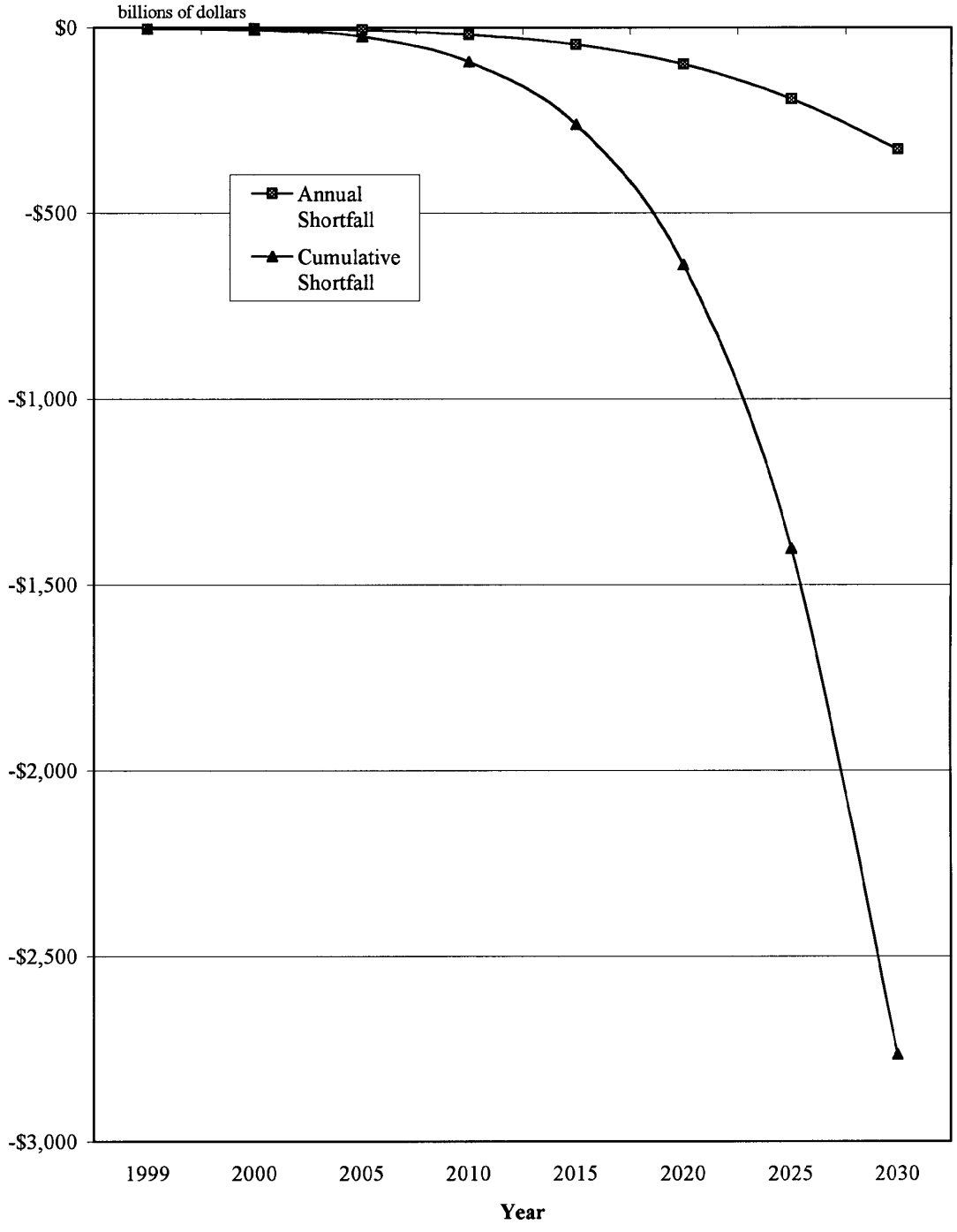
TABLE 3.35. Hospital Insurance Cumulative Shortfall, 1999–2030

(in billions)

Calendar Year	HI Income	HI Total Incurred Outgo	Annual Shortfall	Cumulative Shortfall
1999	134.7	138.4	−3.7	−3.7
2000	140.8	143.3	−2.5	−6.2
2005	176.6	182.9	−6.3	−24.4
2010	226.8	245.8	−19.0	−92.3
2015	288.4	334.6	−46.2	−262.0
2020	364.6	463.8	−99.2	−639.4
2025	459.3	652.9	−193.7	−1402.3
2030	577.9	907.6	−329.7	−2765.4

Note: Table prepared by CRS; totals may not add due to rounding

Figure 3.35. Hospital Insurance Cumulative Shortfall, Calendar Years 1999-2030



Source: Figure prepared by CRS based on 1999 HI Trustees Report (under intermediate assumptions) and personal communication with HCFA staff.

Figure 3.36.
Medicare Part A Trust Fund:
Number of Workers Per Beneficiary, for Selected Years

The ratio of the number of workers paying a payroll tax to the number of beneficiaries receiving services will begin to decline rapidly when the baby boom generation (individuals born between 1946 and 1964) begins to reach 65 in 2011. In 1970, there were 4.4 workers paying a payroll tax for every beneficiary receiving benefits. This ratio dropped to 3.9 workers per beneficiary by 1997. It is expected to further decline to 3.6 workers per beneficiary in 2010 and to 2.3 in 2030 as the last of the "baby boomers" reaches age 65. The ratio is expected to eventually stabilize at around 2 workers per beneficiary.

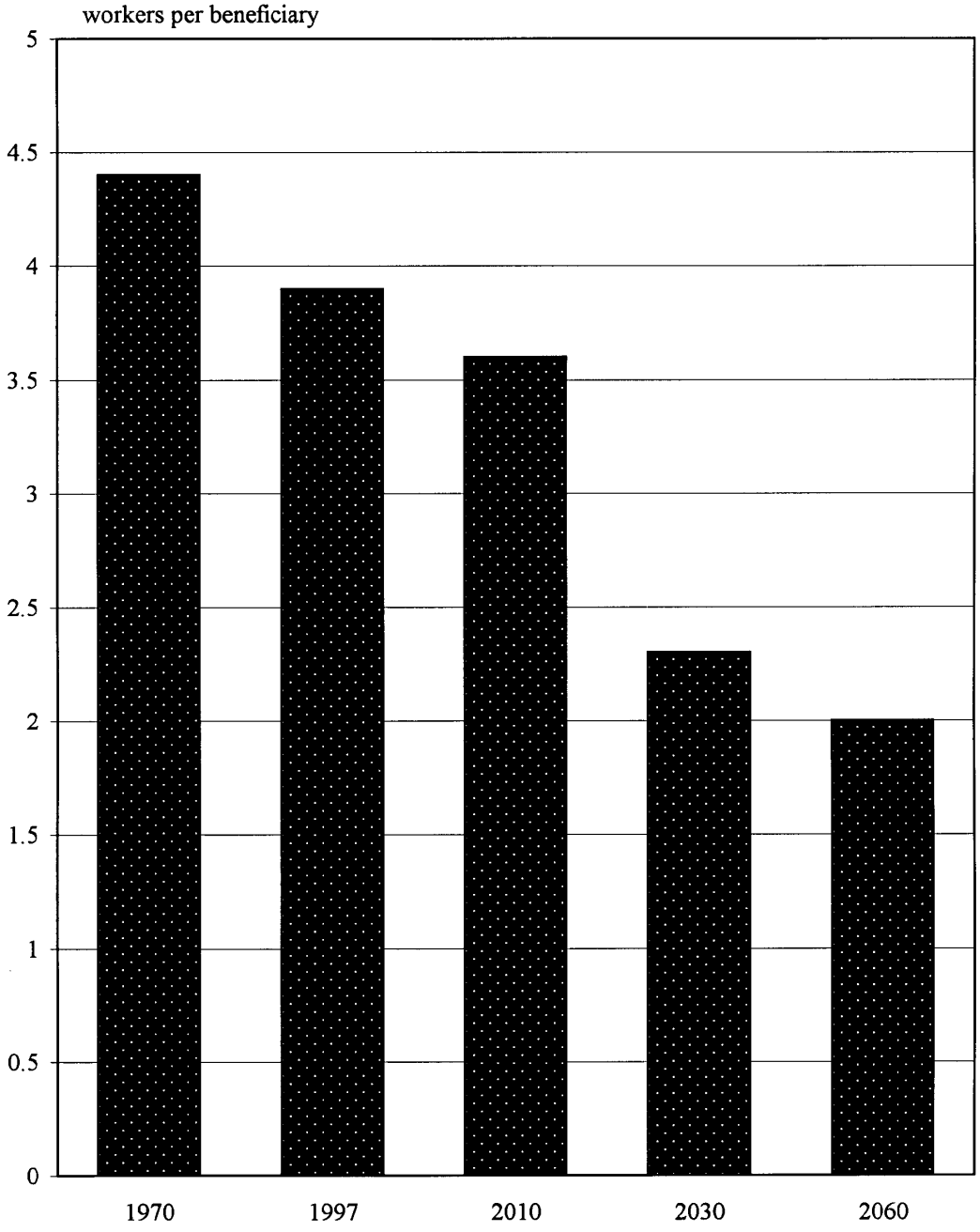
The declining worker/beneficiary ratio reflects the high baby boom birthrate (which peaked at 26.6 births per 1,000 population in 1947) as well as a steadily declining birthrate beginning in the late 1950s. From 1957 to 1994 the rate declined from 25.3 per 1,000 to an estimated 15.0 per 1,000.

TABLE 3.36. Medicare Part A Trust Fund: Number of Workers per Beneficiary, for Selected Years

Calendar Year	Workers Per Beneficiary
1970	4.4
1997	3.9
2010	3.6
2030	2.3
2060	2.0

Note: Based on intermediate assumptions. For 1970, workers covered by OASDI are used as a proxy for covered HI workers. Table prepared by CRS.

Figure 3.36. Medicare Part A Trust Fund: Number of Workers Per Beneficiary, for Selected Years



Source: Figure prepared by CRS based on *1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*.

Figure 3.37.
Medicare Part B Premium as a Percent of Total Part B Trust Fund Disbursements, FY1970–FY1999

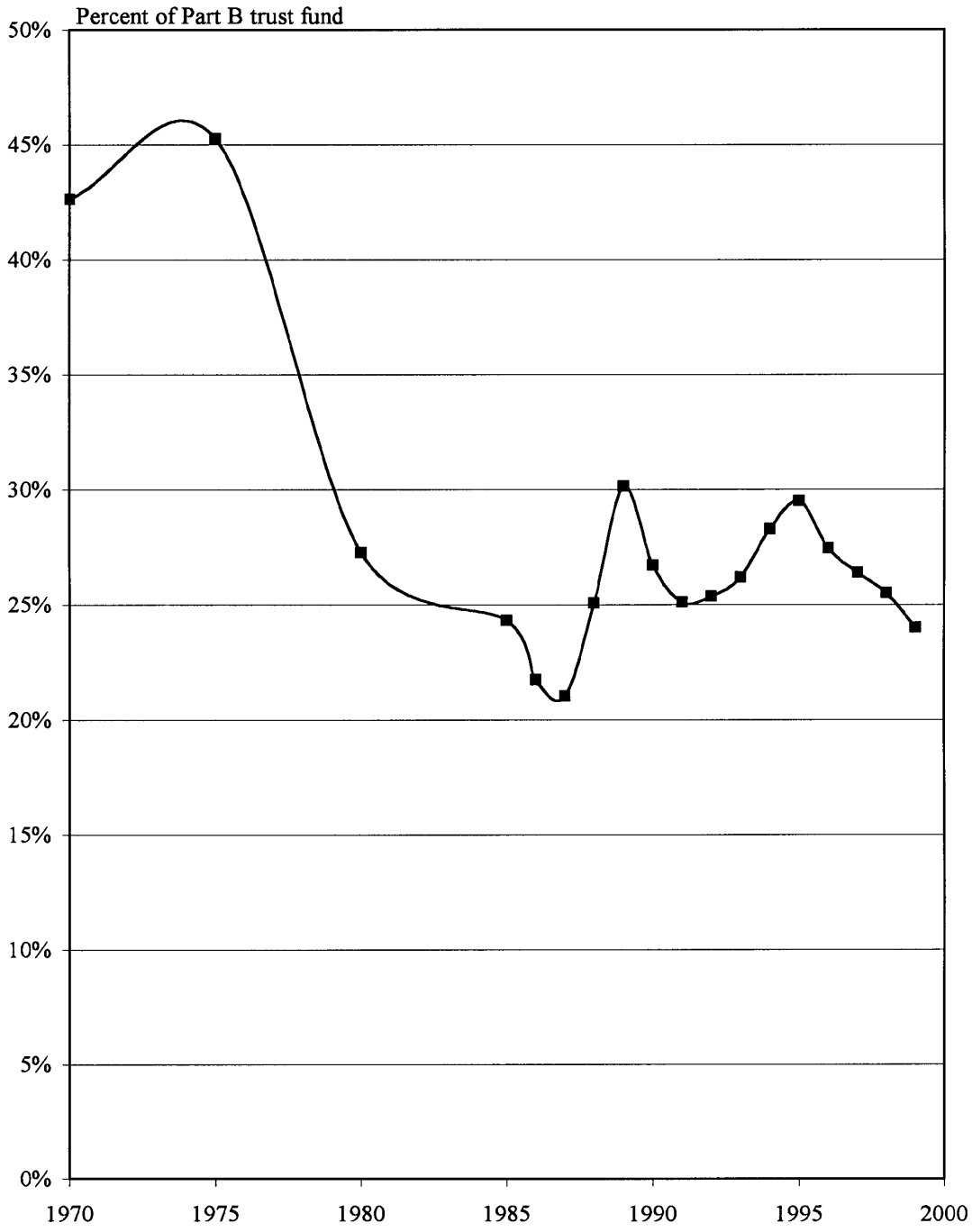
The Part B premium paid by Medicare beneficiaries was originally intended to equal 50% of program costs; general revenues financed the remainder. Legislation enacted in 1972 limited annual increases to the percentage increase in Social Security benefits (the cost-of-living adjustment, or COLA.) As a result, beneficiary contributions dropped to below 25% of program costs by the early 1980s. Since the early 1980s, Congress regularly voted to set the Part B premium equal to 25% of costs for the aged. (The disabled pay the same premium.) However, the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) set specific dollar figures, rather than a percentage, in law for 1991–1995. Because Part B costs rose more slowly than had been anticipated in 1990, the 1995 premium actually represented 31.5% of program costs for the aged. The Omnibus Budget Reconciliation Act of 1993 set the 1996–1998 premiums at 25% of program costs for the aged. BBA 97 permanently sets the Part B premium at 25% of program costs for the aged.

TABLE 3.37. Medicare Part B Premium as a Percent of Total Part B Trust Fund Disbursements, FY1970–FY1999

Year	Premium from Beneficiaries (in millions)	Total Disbursements (in millions)	Percent of Total
1970	$936	$2,196	42.6
1975	1,887	4,170	45.3
1980	2,928	10,737	27.3
1985	5,524	22,730	24.3
1986	5,699	26,218	21.7
1987	6,480	30,837	21.0
1988	8,756	34,947	25.1
1989	11,548	38,317	30.1
1990	11,494	43,022	26.7
1991	11,807	47,019	25.1
1992	12,748	50,288	25.3
1993	14,683	56,059	26.2
1994	16,895	59,724	28.3
1995	19,244	65,213	29.5
1996	18,931	68,946	27.5
1997	19,141	72,553	26.4
1998	19,427	76,272	25.5
1999	19,947	83,126	24.0

Note: Table prepared by CRS.

Figure 3.37. Medicare Part B Premium as a Percent of Total Part B Trust Fund Disbursements, FY1970-FY1999



Source: Figure prepared by CRS based on *1999 Annual Report of the Board of Trustees of the Federal Supplemental Insurance Trust Fund*.

Figure 3.38.
Sources of Payment for Health Care, for All Beneficiaries, Elderly and Disabled, 1994

Medicare does not cover all of the health care expenditures for program beneficiaries. Medicare requires cost-sharing for most covered services, provides only limited protection for some services (such as outpatient prescription drugs and long-term care), and includes no protection against the costs of other services. As a result, Medicare financed only 53% of the medical bills for Medicare beneficiaries in 1994. The program covered 55% of the costs for the aged, but only 40% of the costs for the disabled. This difference was offset, in large measure, by higher Medicaid payments for the disabled (25% vs. 12%). Private insurance covered 10% of medical expenses for the elderly and 8% for the disabled. Both groups paid a portion of their total bill out-of-pocket—20% for the aged and 13% for the disabled.

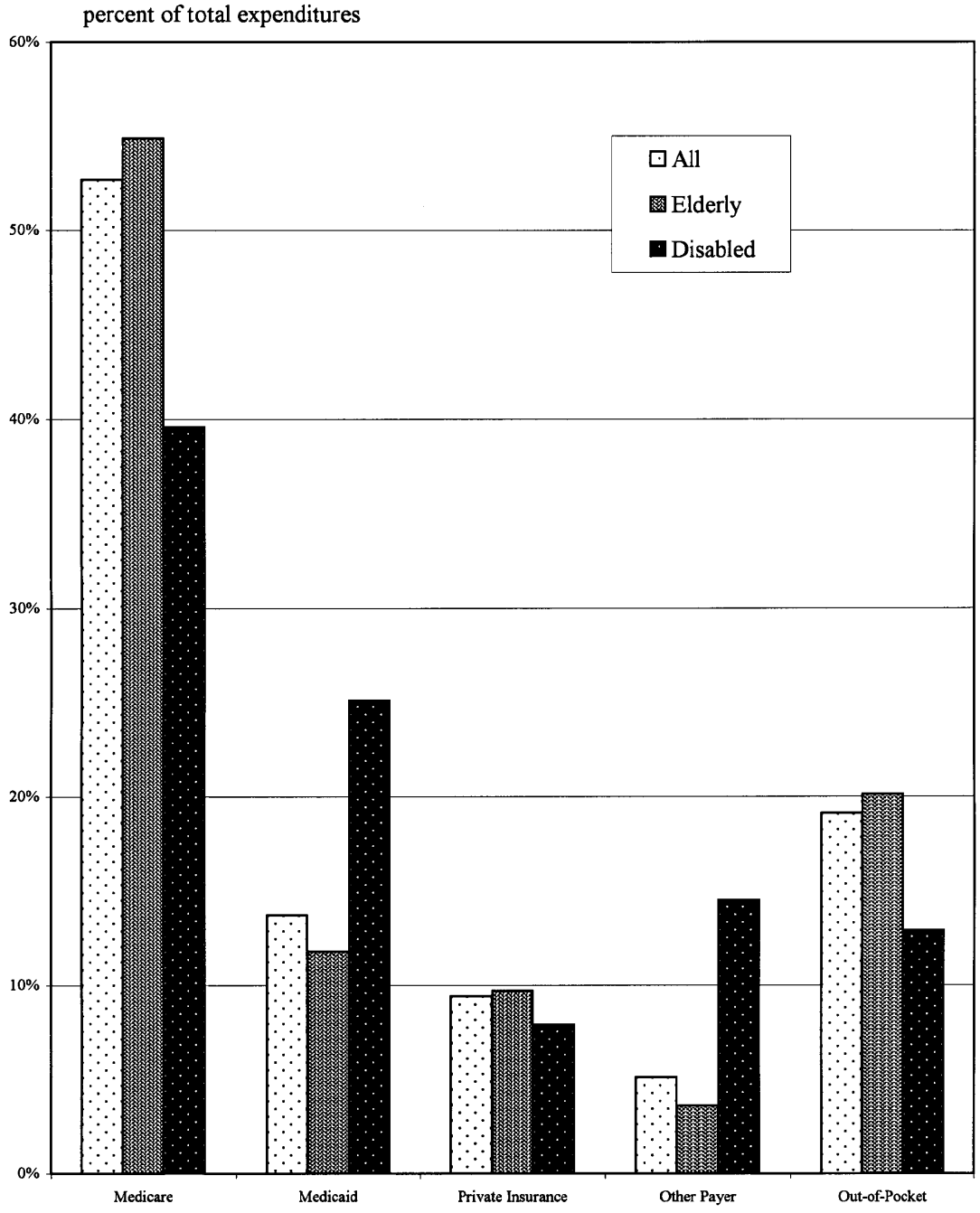
TABLE 3.38 Sources of Payment for Health Care, for all Beneficiaries, Elderly and Disabled, 1994

(in percent)

	Medicare	Medicaid	Private Insurance	Other Payer	Out-of-Pocket
All	52.7	13.7	9.4	5.1	19.1
Elderly	54.9	11.8	9.7	3.6	20.1
Disabled ..	39.6	25.1	7.9	14.5	12.9

Note: Rows may not add to 100% due to rounding. Table prepared by CRS.

Figure 3.38. Sources of Payment for Health Care, for All Beneficiaries, Elderly and Disabled, 1994



Source: Olin, Gary L., and Hongji Liu. *Health and Health Care of the Mediare Population: Data from the 1994 Medicare Current Beneficiary Survey.* Rockville, Maryland, Westat (Nov. 1998).

Figure 3.39.
Spending for Health as a Percentage of After-Tax Income, Elderly and Non-Elderly Households, 1960–1994

Most persons spend a portion of their incomes out-of-pocket for health care. This spending includes payments for health insurance, cost-sharing charges incurred for use of insurance-covered medical care, as well as costs for services not covered by insurance. The percentage of after-tax income that the elderly spend on health care has risen from 11% in the early 1960s to 18% in 1994. In contrast, the percentage spent by nonelderly households has remained relatively constant—declining from 6% in the early 1960s to 5% in 1994. The higher percentage spent by the elderly reflects several factors, including their higher utilization of health care, their payments for long-term care services and the premiums paid by those elderly persons who purchase supplemental insurance (i.e., "Medigap") policies.

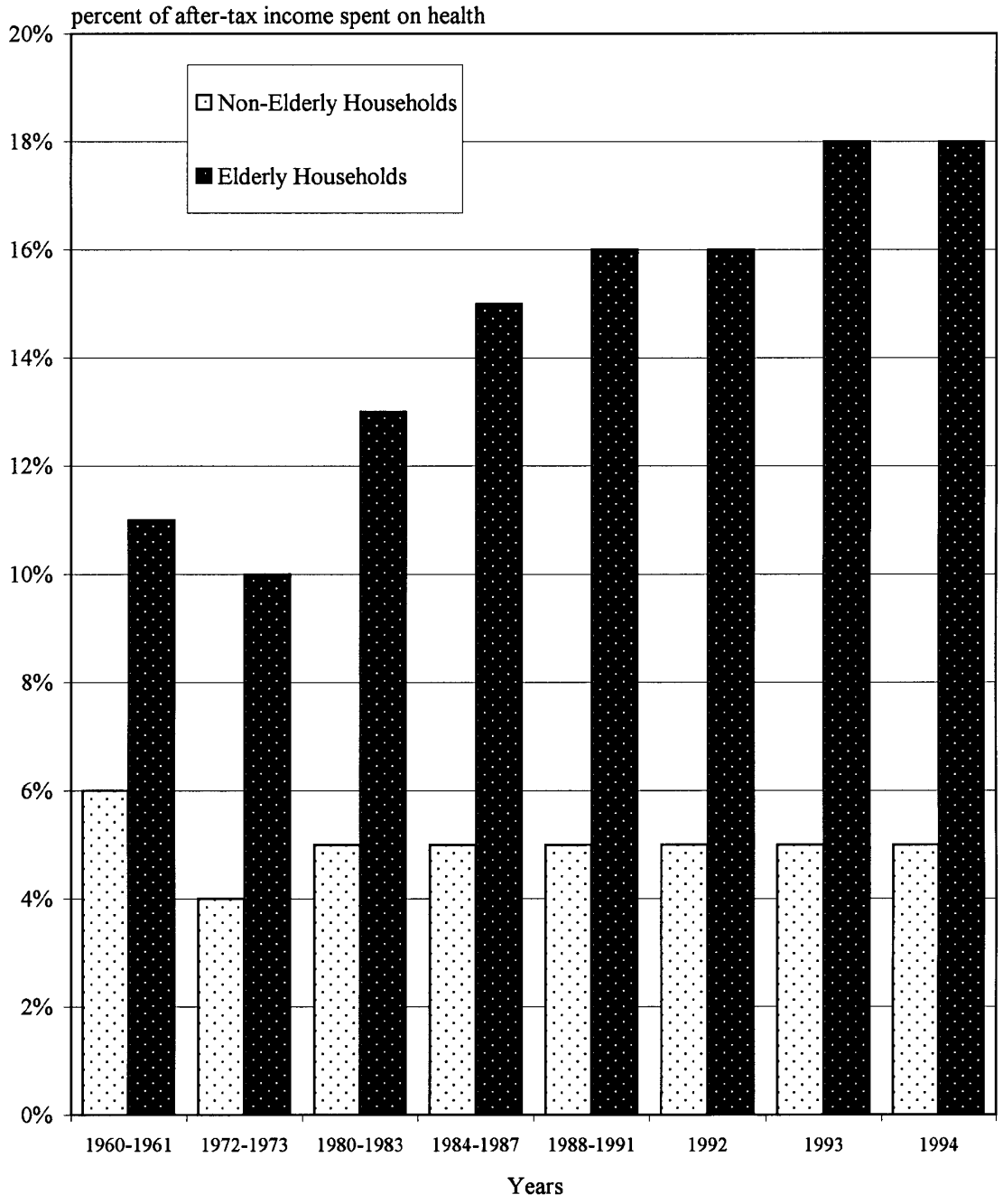
TABLE 3.39. Spending for Health as a Percentage of After-Tax Income, Elderly and Non-Elderly Households, 1960–1994

(percent of after-tax income)

Year(s)	Nonelderly Households	Elderly Households
1960–1961	6	11
1972–1973	4	10
1980–1983	5	13
1984–1987	5	15
1988–1991	5	16
1992	5	16
1993	5	18
1994	5	18

Note: Includes spending for health insurance, medical services, prescription drugs, and medical supplies. Definition of elderly or nonelderly households is based on designation of reference person. Table prepared by CRS.

Figure 3.39. Spending for Health as a Percentage of After-Tax Income, Elderly and Non-Elderly Households, 1960-1994



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996.*
NOTE: Includes spending for health insurance, medical services, prescription drugs and medical suppliers.

Figure 3.40.
Out-of-Pocket Health Spending, 1995

Despite Medicare's near universal coverage of the elderly population, half of this age group spends at least 14.4% of after-tax income out-of-pocket on health care costs. These costs include health insurance premiums, co-payment of medical bills, and medical costs that are not covered by insurance (such as prescription drugs).

As shown in the top chart, the highest out-of-pocket health spending, expressed as a percent of after-tax income, is concentrated among the "near poor" elderly (whose income is between the poverty line and 2 times the poverty line). The near poor, who make up one-quarter of all non-institutionalized elderly persons, spend from 45% to 61% of their income on out-of-pocket health costs. In contrast, the top one-quarter of elderly, with income at least 4 times the poverty line, spent 6.5% of after-tax income out-of-pocket on health costs.

It is important to note that these estimates of "average" out-of-pocket spending are not based on mean calculations, which are subject to distortion by extreme values (either very high or very low scores). Instead, they are based on calculations of medians. The median is the score in the middle of a distribution. It is not swayed by extreme scores at either end of a distribution.

Compared to the non-elderly, the elderly spend 75% more (in dollar terms) on out-of-pocket health care costs ($2,678 vs. $1,510, on average, in 1994), but they earn less than half as much ($19,449 vs. $40,941 in 1996).[9] As a share of their after-tax income, the elderly spend about 3 times more than the non-elderly on out-of-pocket health costs. Moreover, as shown in the chart at the bottom of opposite page, this difference is not because the elderly spend less on other necessities. The elderly also spend a larger share of their income on food and housing than do the non-elderly.

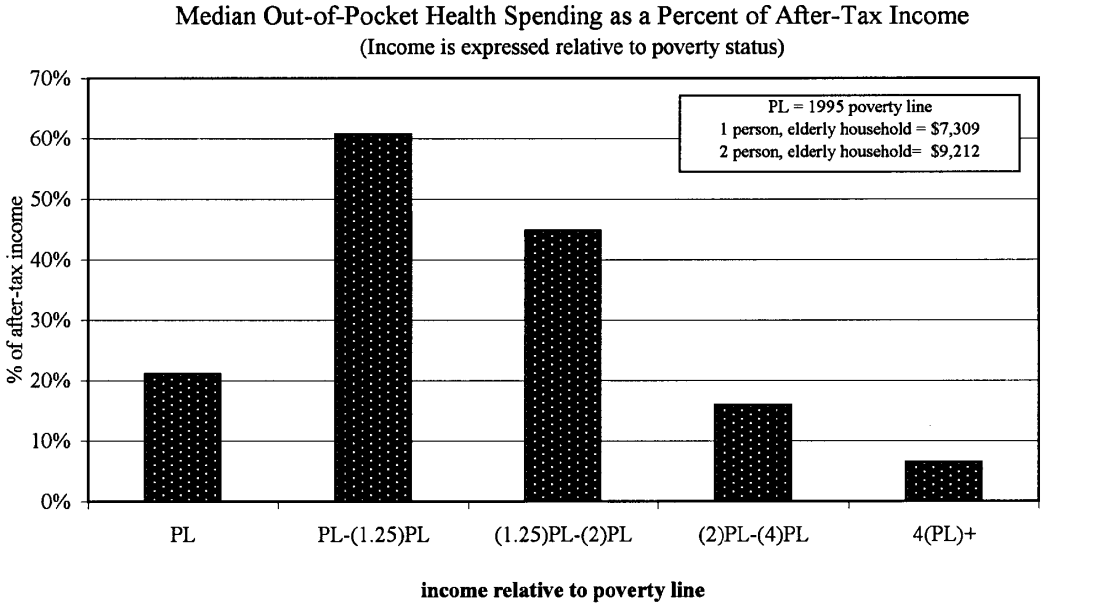
TABLE 3.40. Median Out-of-Pocket Health Spending as a Percent of After-Tax Income, 1995

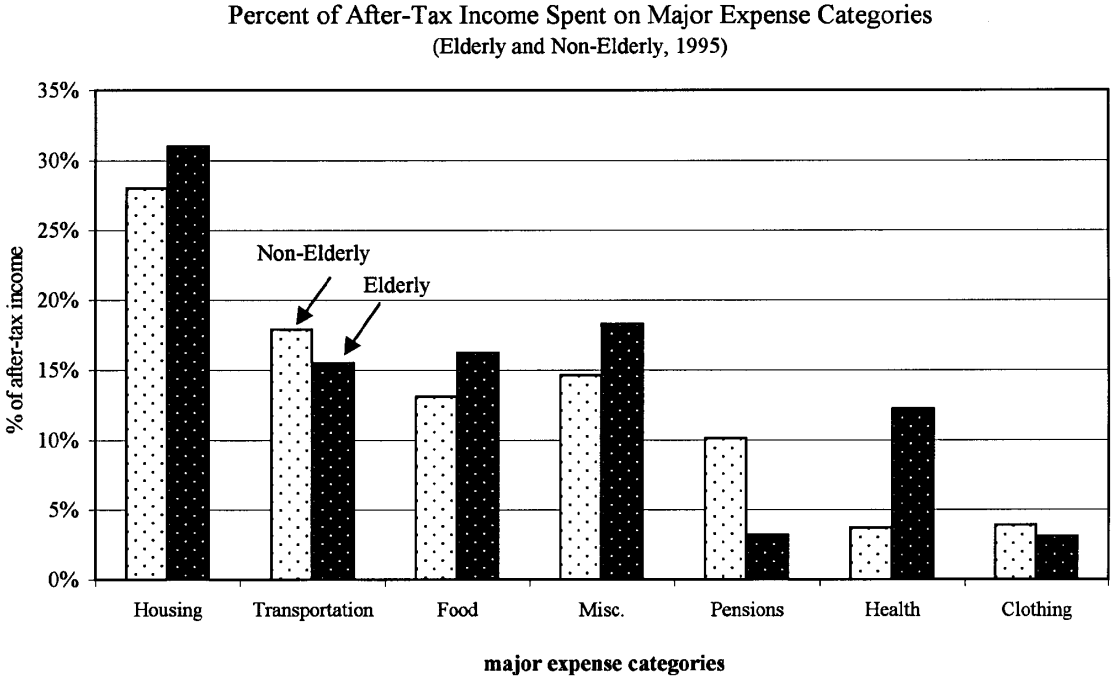
Income Relative to Poverty Status	Percent Out-of-Pocket	Percent of Elderly
Below poverty line (PL)	21.1%	9.2%
PL–(1.25) PL	60.7	5.3
(1.25) PL–(2) PL	44.8	21.1
(2) PL–(4) PL	15.9	37.9
(4) PL + ...	6.5	26.6
All elderly	14.4	.....

Note: Data for elderly includes non-institutionalized household expenditures for health insurance, medical services, drugs, and medical supplies.

[9] "Consumer Expenditures in 1994," U.S. Department of Labor, Bureau of Labor Statistics, Report 902, February 1996, Table 3, page 8.

Figure 3.40. Out-of-Pocket Health Spending, 1995





Source: CRS Report 98-534, *Medicare: Out-of-Pocket Health Spending*, by Jason S. Lee.

Figure 3.41.
Sources of Health Insurance for Medicare Beneficiaries, 1996

The majority of Medicare beneficiaries depends on one or more supplemental insurance policies or Medicaid to help pay for services not covered by Medicare and for the program's cost-sharing requirements. In 1996 about 63% of the Medicare population had private supplemental insurance. Private insurance protection may be obtained through a current or former employer. It may also be obtained through an individually-purchased policy (commonly referred to as a "Medigap" policy). About 17% had Medicaid coverage; about half of these persons had full Medicaid coverage while the remainder had coverage just for Medicare's cost-sharing and premium costs under the Qualified Medicare Beneficiary (QMB) program or for premium charges only under the Specified Low Income Beneficiary (SLIMB) program. Two percent of the Medicare population had supplemental coverage from one of a variety of public sources (such as the military).

Over 19% of the Medicare population had no supplementary coverage. However, there was a large difference between the traditional fee-for-service sector where 13% had no supplementary coverage and the managed care sector where 63% had no supplementary coverage. Managed care organizations often provide coverage for services in addition to those covered under the traditional fee-for-service program.

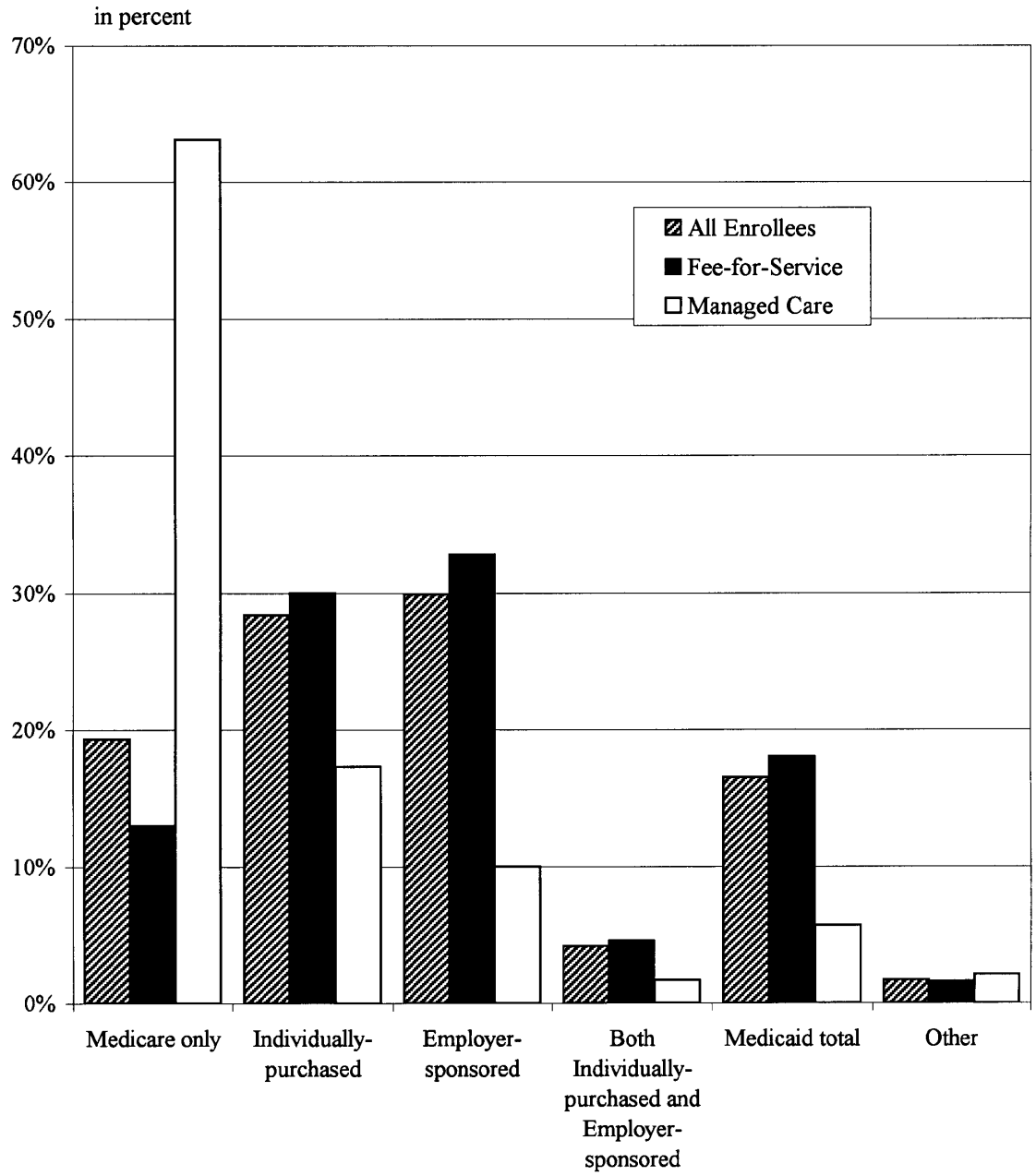
TABLE 3.41. Distribution of Supplementary Health Insurance for Medicare Beneficiaries, 1996

(in percent)

Type of Insurance	All Beneficiaries	Fee-for-Service Enrollees	Managed Care Enrollees
Medicare only	19.3	13.0	63.1
Individually-purchased	28.4	30.0	17.3
Employer-sponsored	29.9	32.8	10.0
Both private types	4.2	4.6	1.7
Medicaid, total	16.5	18.0	5.7
Full Medicaid	8.3	9.1	2.4
Qualified Medicare Beneficiary (QMB)	7.4	8.1	2.6
Specified Low-Income Beneficiary	0.8	0.8	0.7
Other	1.7	1.6	2.1

Note: Table prepared by CRS.

Figure 3.41. Sources of Health Insurance for Medicare Beneficiaries, 1996



Source: Eppig, Franklin J., and George Chulis. Trends in Medicare Supplementary Insurance: 1992-1996. *Health Care Financing Review/Fall 1997,* v. 19, no. 1.

Section 4.
Medicare Risk HMOs and Medicare+Choice

Effective in 1999, the Medicare+Choice program, authorized by the Balanced Budget Act of 1997 (BBA 97, P. L. 105–33), replaced the Medicare risk contract program that had originally been authorized in 1982. This section includes data for the pre-1999 Medicare risk contract program and the new Medicare+Choice program.

Under both programs, a private health care organization contracts with the government to provide all Medicare-covered health care to Medicare beneficiaries who elect to enroll in the private plan instead of traditional Medicare; the plan assumes the full cost risk of providing services to its beneficiaries for a fixed annual "capitation payment" per beneficiary paid by the government.

In creating the Medicare+Choice program, the BBA 97 changed the formula determining the government's payment to Medicare risk HMOs and Medicare+Choice plans per beneficiary; created new rules for beneficiary enrollment and disenrollment; and required that plan comparison information be made available to beneficiaries. It also expanded the types of private plans that can contract with Medicare to include managed care organizations such as preferred provider organizations and provider-sponsored organizations, private fee-for-service plans, and, on a limited demonstration basis, high-deductible plans offered in conjunction with medical savings accounts (MSAs). As of January 1999, only one non-HMO, a provider-sponsored organization, had contracted to provide services. As is the case for HMOs, organizations seeking to contract as Medicare+Choice plans will have to meet specific organizational, financial, and other requirements.

The new method for paying risk HMOs and Medicare+Choice plans took effect on January 1, 1998. The changes were designed to reduce the wide variation in payments and the year-to-year volatility that resulted from the old rules, especially in less-populated counties. Payments under the new system are based on a blend of local rates (using the 1997 adjusted average per capita cost, or "AAPCCs") and national rates. Payment floors are applied to raise rates in certain counties more quickly than would have occurred based on blended rates alone. County rates are guaranteed to increase by a minimum of 2%. The resulting 1999 rates range from a minimum of $380 to a high of $798. Further changes will be phased in through 2003. Actual payments to plans vary based on characteristics of the enrolled population (e.g., age, gender, and whether or not the individual is in a nursing home). New risk adjusters reflecting enrollees' health status are scheduled to be implemented in January 2000.

Medicare+Choice enrolls about 16% of beneficiaries (February, 1999). This section provides information on the number and location of Medicare risk HMOs and Medicare+Choice plans, and the number, geographic distribution, and characteristics of beneficiaries enrolled in these plans. Comparisons are drawn between Medicare HMO enrollees and beneficiaries in Medicare fee-for-service, and examples of current and proposed changes in risk adjustment are given. Information is also provided on Medicare payments to Medicare+Choice providers and geographic variation in these payments, including how such payments have changed under BBA 97.

Figure 4.1.
Medicare+Choice Plans and Risk HMOs Participating in Medicare, 1987–1999

The Medicare+Choice program began operation on January 1, 1999, as authorized by the Balanced Budget Act of 1997 (BBA). Prior to this program, risk HMOs were authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and were sometimes called TEFRA HMOs. The BBA allows for risk contracts with organizations besides HMOs, including provider sponsored organizations (PSOs), preferred-provider organizations (PPOs), and private fee-for-service plans. Further, under a demonstration program, a limited number of beneficiaries are able to establish medical savings accounts (MSAs) in conjunction with a high deductible plan. By February 1999, one PSO and 298 HMOs had contracted with HCFA under the Medicare+Choice program. Under both the BBA and TEFRA, providers receive a predetermined monthly payment amount from Medicare for each enrolled beneficiary, regardless of the actual medical care utilization of the enrollee. Beginning in 2000, payments will be modified using a new mechanism for risk adjustment.

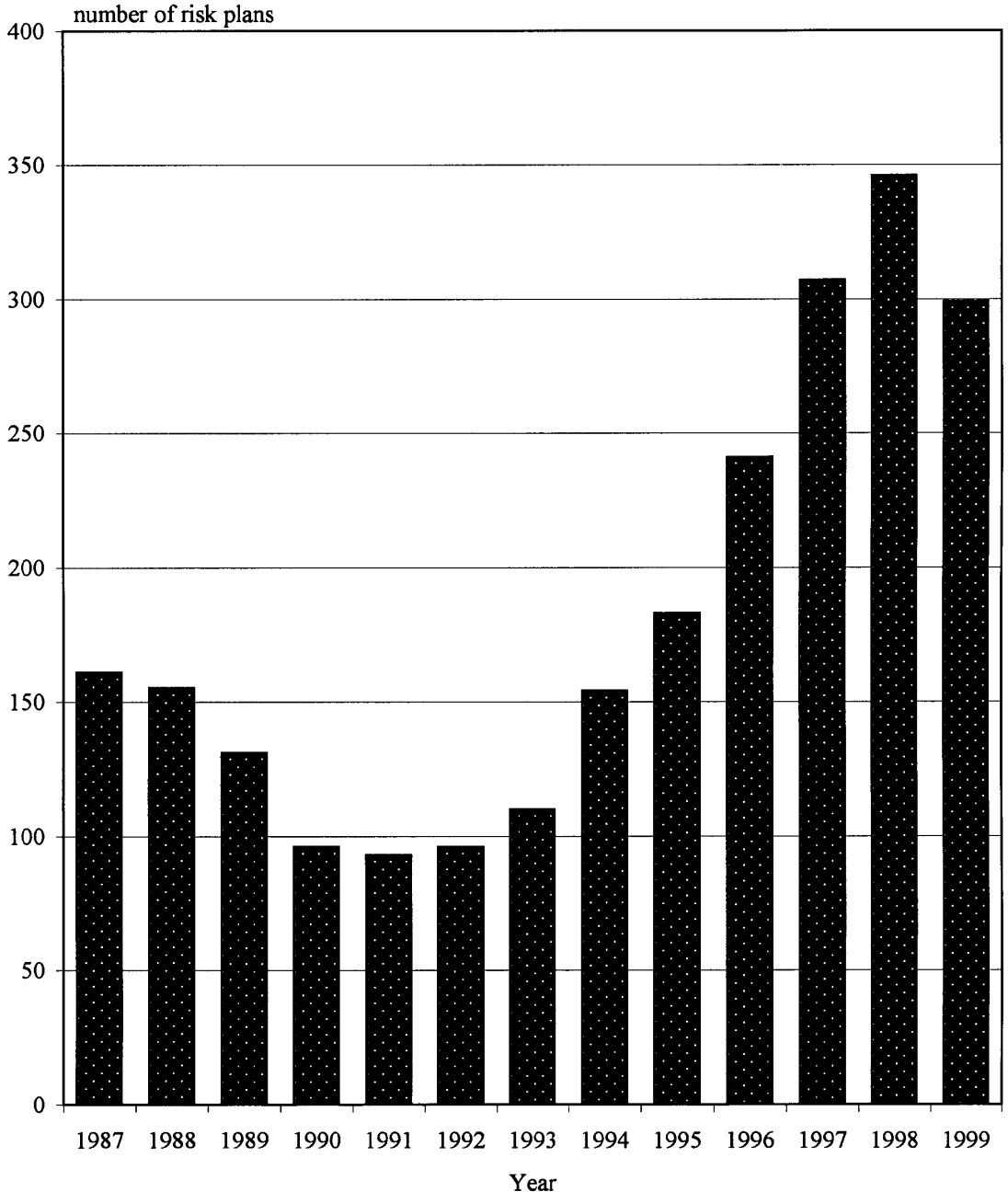
Participation of risk contract HMOs in Medicare declined from 1987 to the early 1990s as many plans terminated existing contracts. However, the total number of health plans signing risk contracts with the Medicare program tripled between 1993 and 1998. With the beginning of the Medicare+Choice program in 1999, a number of plans withdrew from the Medicare risk program or reduced the size of their service areas. These reductions left fewer providers of Medicare managed care under the Medicare+Choice program than previously served Medicare beneficiaries. Yet, in February 1999, 28 Medicare+Choice plans had pending applications and 16 had pending service area expansions.

TABLE 4.1. Medicare+Choice Plans and Risk HMOs Participating in Medicare, 1987–1999

Year	Number of Plans	Year	Number of Plans
1987	161	1994	154
1988	155	1995	183
1989	131	1996	241
1990	96	1997	307
1991	93	1998	346
1992	96	1999	299
1993	110	.....	.....

Note: Table prepared by CRS. 1998 data from December; 1999 data from February, and includes one PSO.

Figure 4.1. Medicare+Choice Plans and Risk HMOs Participating in Medicare, 1987-1999



Source: Figure prepared by CRS based on Health Care Financing Administration (HCFA), Medicare Managed Care Contract Report, December 1998, February, 1999. Note February 1999 count includes 1 PSO.

Figure 4.2.
Beneficiaries Enrolled in Medicare Risk HMOs and Medicare+Choice Plans, Actual and Projected, 1990–2002

There was a steady growth in enrollment in Medicare risk HMOs during the 1990s, reaching 16.1% of all beneficiaries in December 1998. Between 1994 and 1997, enrollment more than doubled. Over the last 5 years, the annual rate of growth was in the range of 25% to 33%. Monthly enrollment growth fell steadily from June through December, 1998—total risk enrollment increased by only 0.6% between November and December. Although HCFA reports changes under Medicare+Choice that produce an understatement of enrollment, the number of Medicare managed care enrollees declined 1% between December 1998 and February 1999. Still, the Congressional Budget Office (CBO) projects that enrollment in Medicare+Choice plans will reach about 19% of all beneficiaries by 2002.

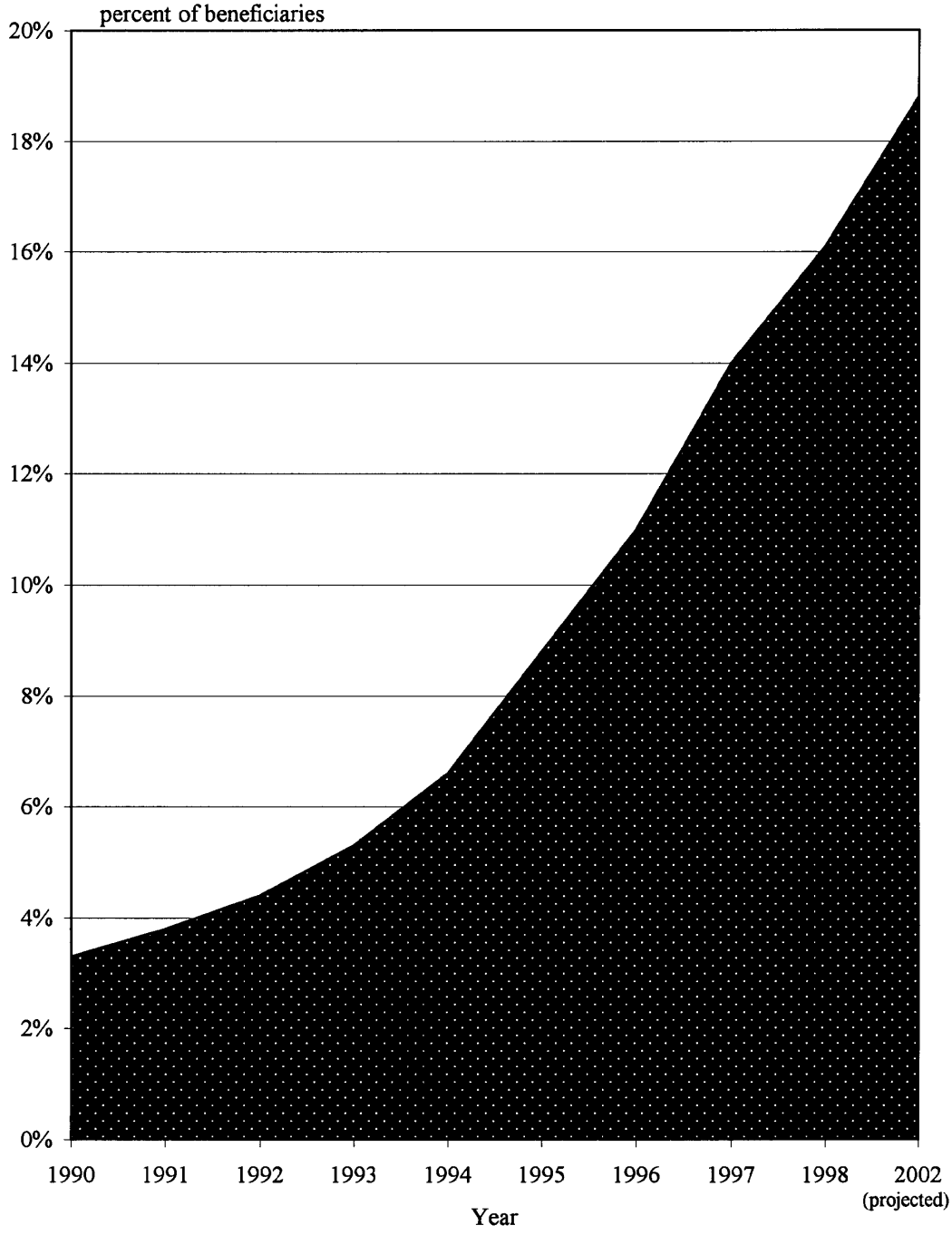
TABLE 4.2. Beneficiaries Enrolled in Medicare Risk HMOs and Medicare+Choice Plans, Actual and Projected, 1990–2002

(in percent)

Year	Enrollment
1990	3.3
1991	3.8
1992	4.4
1993	5.3
1994	6.6
1995	8.8
1996	11.0
1997	14.0
1998	16.1
2002	18.8

Note: Data for year 2002 are projected. Table prepared by CRS.

Figure 4.2. Beneficiaries Enrolled in Medicare Risk HMOs and Medicare+Choice Plans, Actual and Projected, 1990-2002



Source: Prep. by CRS based on *MedPAC Chart Book*, Oct.97, ch 3; CBO, *Jan.99, Medicare Baseline; HCFA, Medicare Managed Care Reports, Dec.98 and Feb.99.*

Figure 4.3.
Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995–1998

Although about 300 Medicare+Choice plans now participate in Medicare, each is available only to beneficiaries in a specific service area. Plans define a service area as a set of counties and county parts, itemized at the zip code level. In March 1998, 72% of all Medicare beneficiaries lived in a zip code that was served by at least one risk plan. Over 60% of all beneficiaries had access to a choice of plans, and almost 40% had five or more plans available to them. From June 1995 to March 1998, an additional 16% of all beneficiaries gained access to at least one risk plan, while the number with access to at least five plans almost tripled.

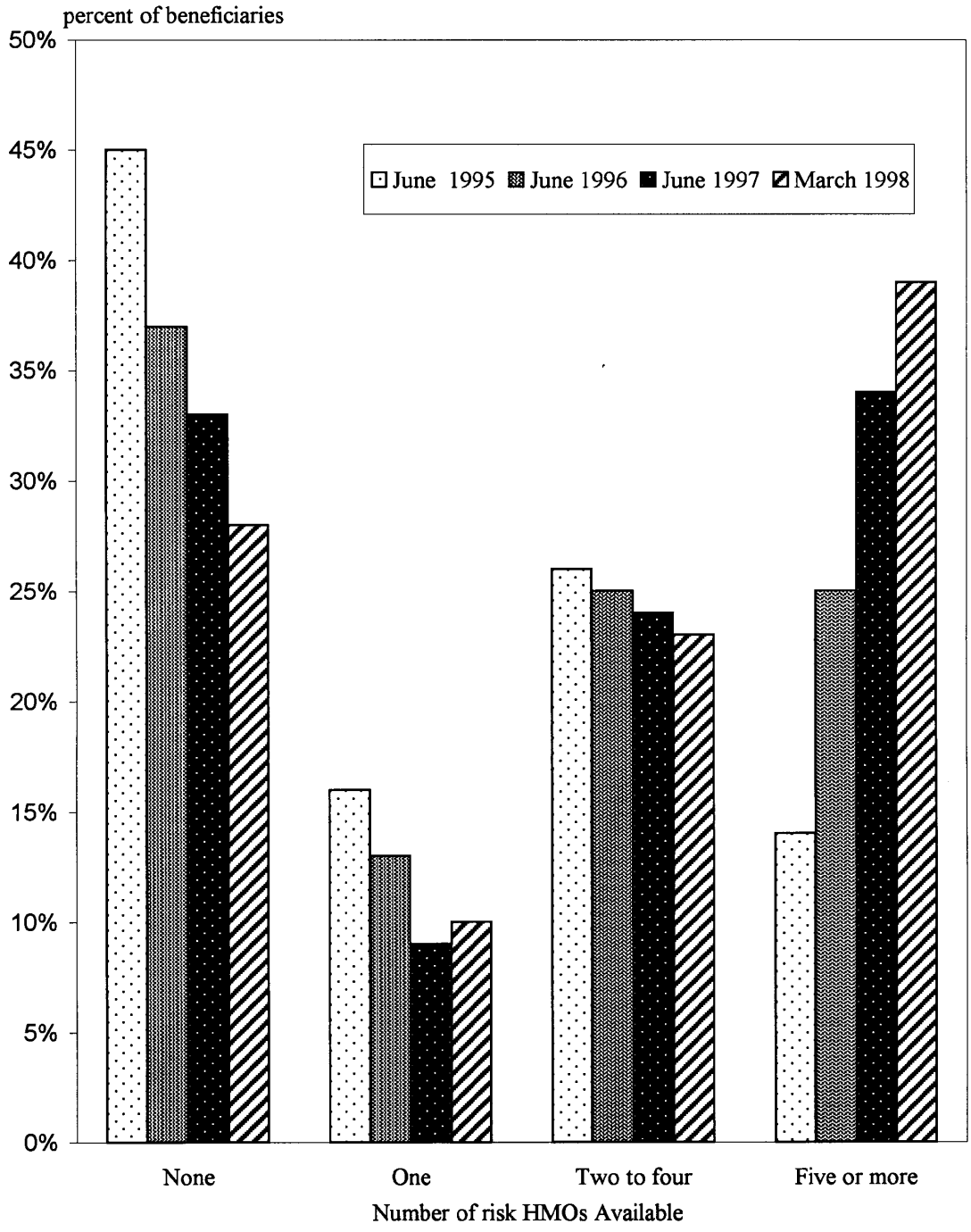
TABLE 4.3. Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995–1998

(in percent)

Number of Risk HMOs Available	June 1995	June 1996	June 1997	March 1998
None	45	37	33	28
One	16	13	9	10
Two to four	26	25	24	23
Five or more	14	25	34	39

Note: Table prepared by CRS based on MedPAC analysis of HCFA data.

Figure 4.3. Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995-1998



Source: Figure prepared by CRS based on *MedPAC Chart Book,* July 1998, Chart 2-10.

Figure 4.4.
Medicare Beneficiaries in Urban and Rural Locations Enrolled in Risk HMOs, March 1998

Patterns of enrollment in risk contract HMOs are not uniform across urban and rural locales. Risk plan enrollment in central urban areas (generally, the cities at the core of metropolitan areas) was about 22.5% in March 1998, which was about twice the level of enrollment in outlying urban areas. Risk HMO enrollment in rural areas was about 1% to 3%.

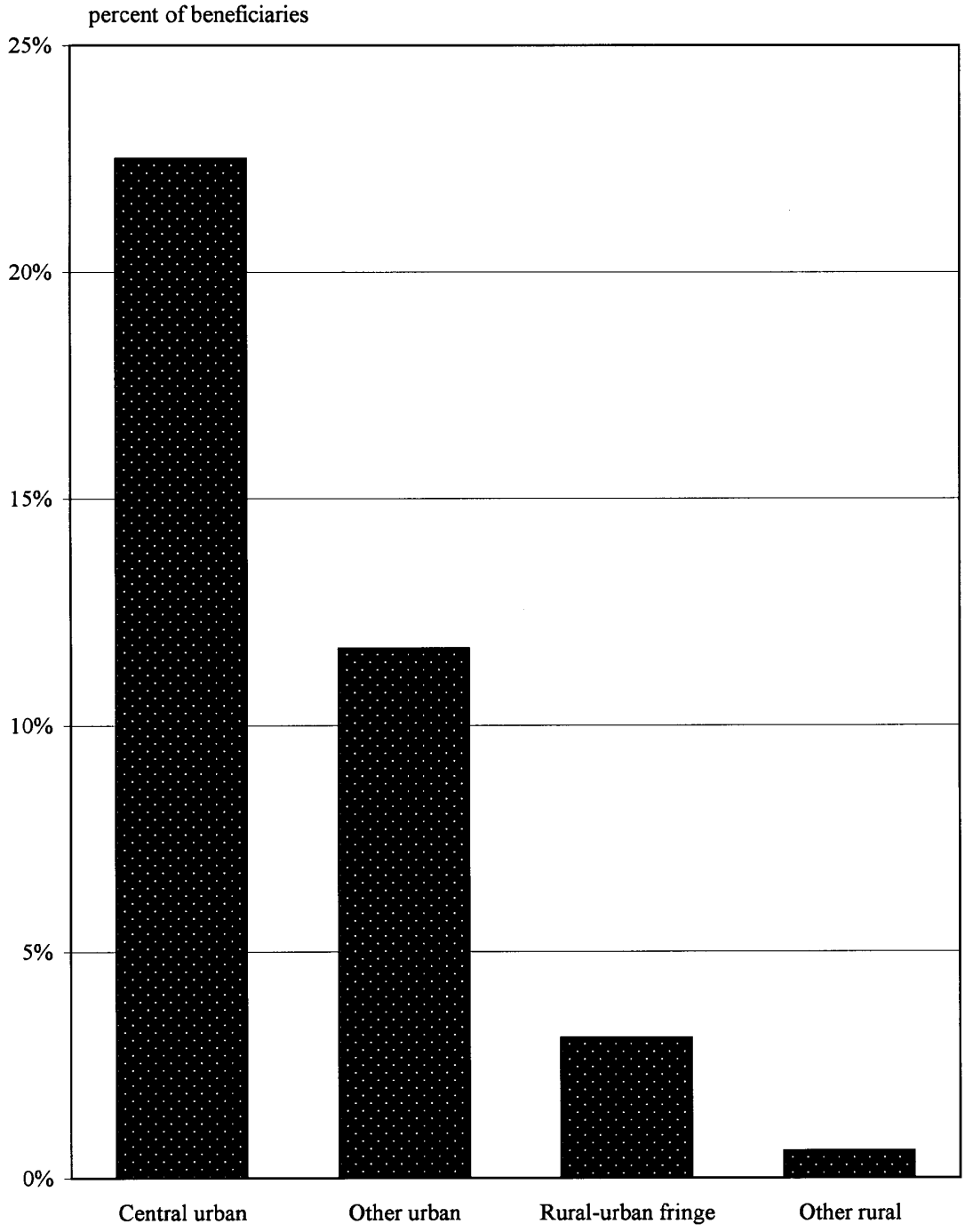
TABLE 4.4. Medicare Beneficiaries in Urban and Rural Locations Enrolled in Risk HMOs, March 1998

(in percent)

	Enrollment in Risk-Contract Plans (in percent)
Central urban	22.5
Other urban	11.7
Rural-urban fringe	3.1
Other rural	0.6

Note: Table prepared by CRS based on MedPAC analysis of HCFA data.

Figure 4.4. Medicare Beneficiaries in Urban and Rural Locations Enrolled in Risk HMOs, March 1998



Source: Figure prepared by CRS based on *MedPAC Chart Book*, July 1998, Chart 2-6.

Figure 4.5.
Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1997

The availability to Medicare beneficiaries of risk contract plans is much greater in urban areas than in rural areas. A choice of Medicare+Choice plans is available to most residents of central urban areas. By contrast, rural beneficiaries rarely have even a single plan available to them. Plan availability had been growing rapidly in both urban and rural locales. For example, the proportion of central urban residents with five or more plans in their areas grew from 39% to 79% from 1995 to 1997. The percentage of rural beneficiaries in urban fringe areas with at least one plan grew from 11% to 30% in that same period.

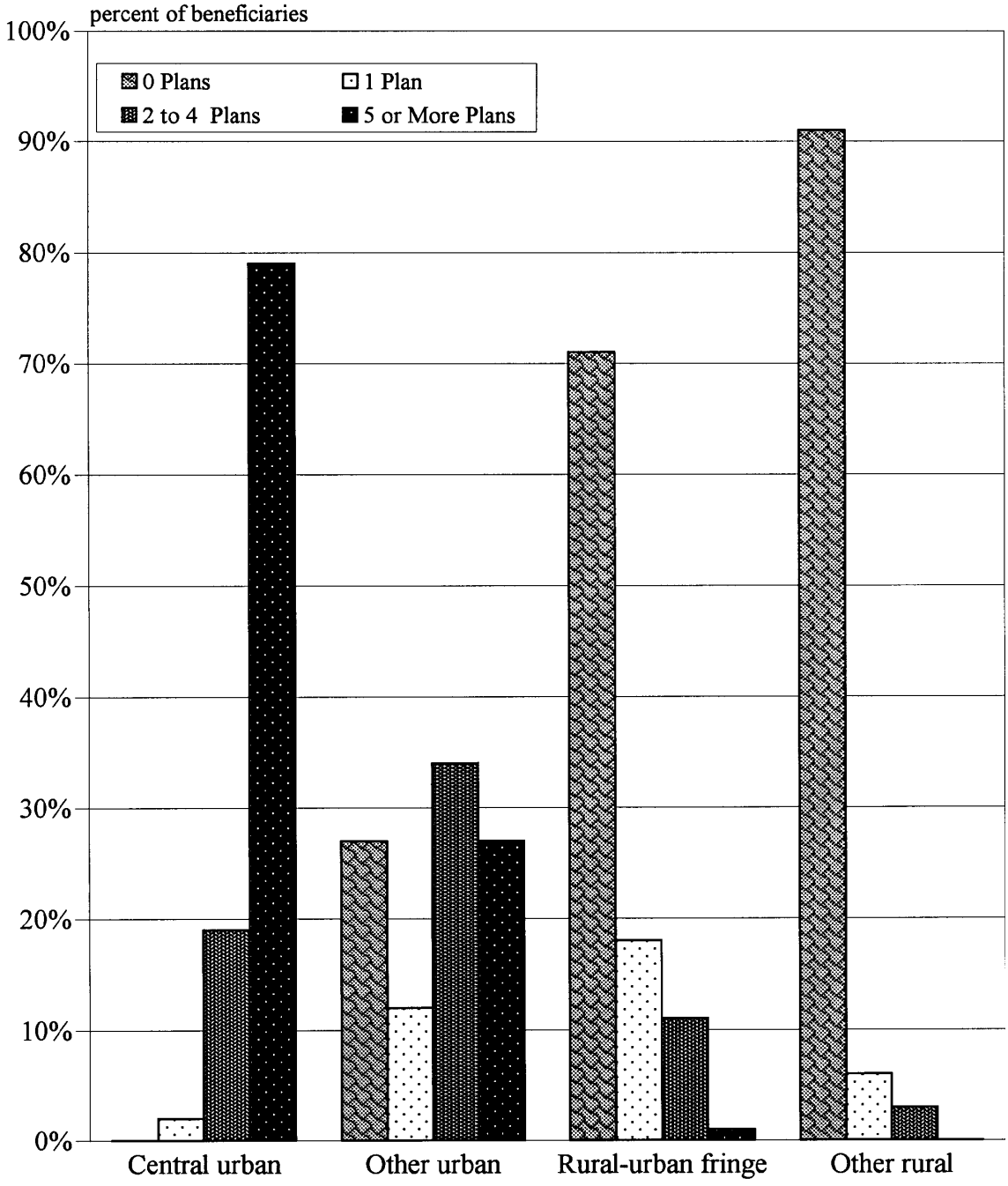
TABLE 4.5. Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1997

(in percent)

	0 Plans	1 Plan	2 to 4 Plans	5 or More Plans
Central urban	0	2	19	79
Other urban	27	12	34	27
Rural-urban fringe ..	71	18	11	1
Other rural	91	6	3	0

Note: Table prepared by CRS based on MedPAC analysis of HCFA data.

Figure 4.5. Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1997

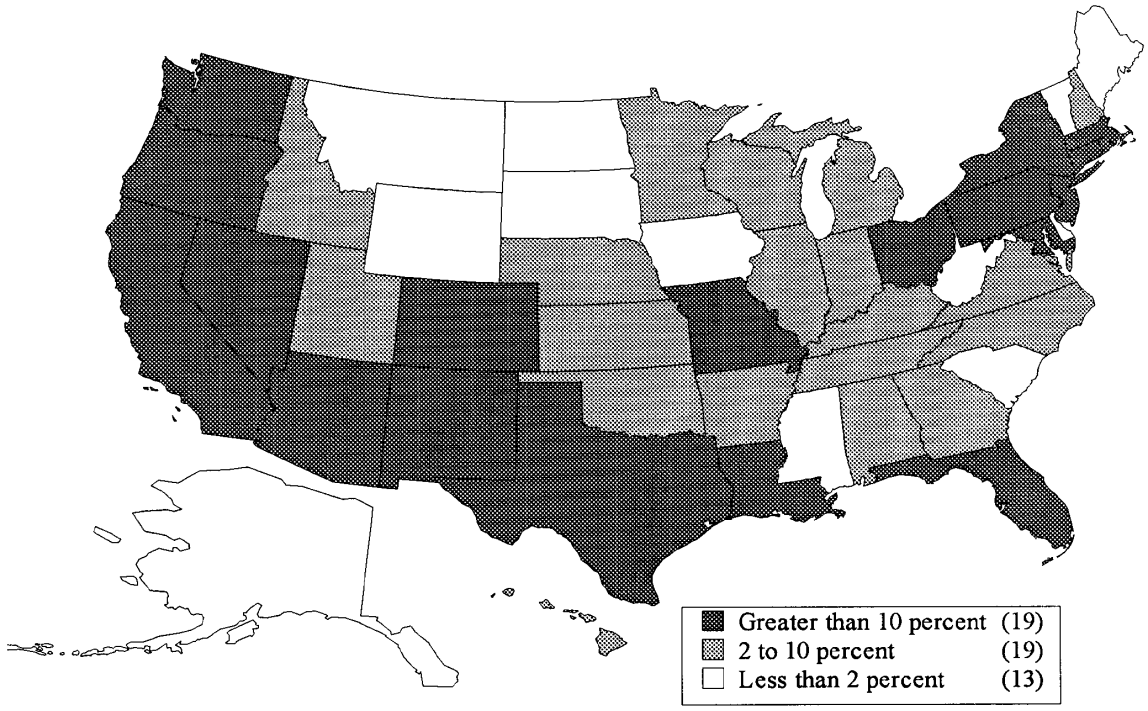


Source: Figure prepared by CRS based on *MedPAC Chart Book*, Oct. 1997, Chart 18.

Figure 4.6.
Medicare Beneficiaries Enrolled in Risk HMOs, by State, December 1998

Enrollment patterns are not uniform on a regional basis. Medicare risk HMO enrollment was much higher in western states. In particular, over one-third of the beneficiaries in Arizona (40%) and California (39%) were in Medicare risk HMOs. The highest levels of enrollment in eastern states were in Rhode Island (38%), Florida (28%), Pennsylvania (26%) and Massachusetts (22%). In contrast, 13 states had no (or marginal) risk HMO plan enrollment, and in many others the enrollment was quite low.

Figure 4.6. Medicare Beneficiaries Enrolled in Risk HMOs, by State, December 1998



SOURCE: Map prepared by CRS based on *Medicare Managed Care Contract Reports,* December 1998.

Figure 4.7.
Distribution of Medicare Risk HMO Enrollees Among Selected States, 1998

Medicare risk HMO enrollees were far more concentrated geographically than Medicare beneficiaries as a whole. As of December 1998, 37% of all Medicare risk HMO enrollees lived in California and Florida, even though only 17% of all beneficiaries lived in those two states.

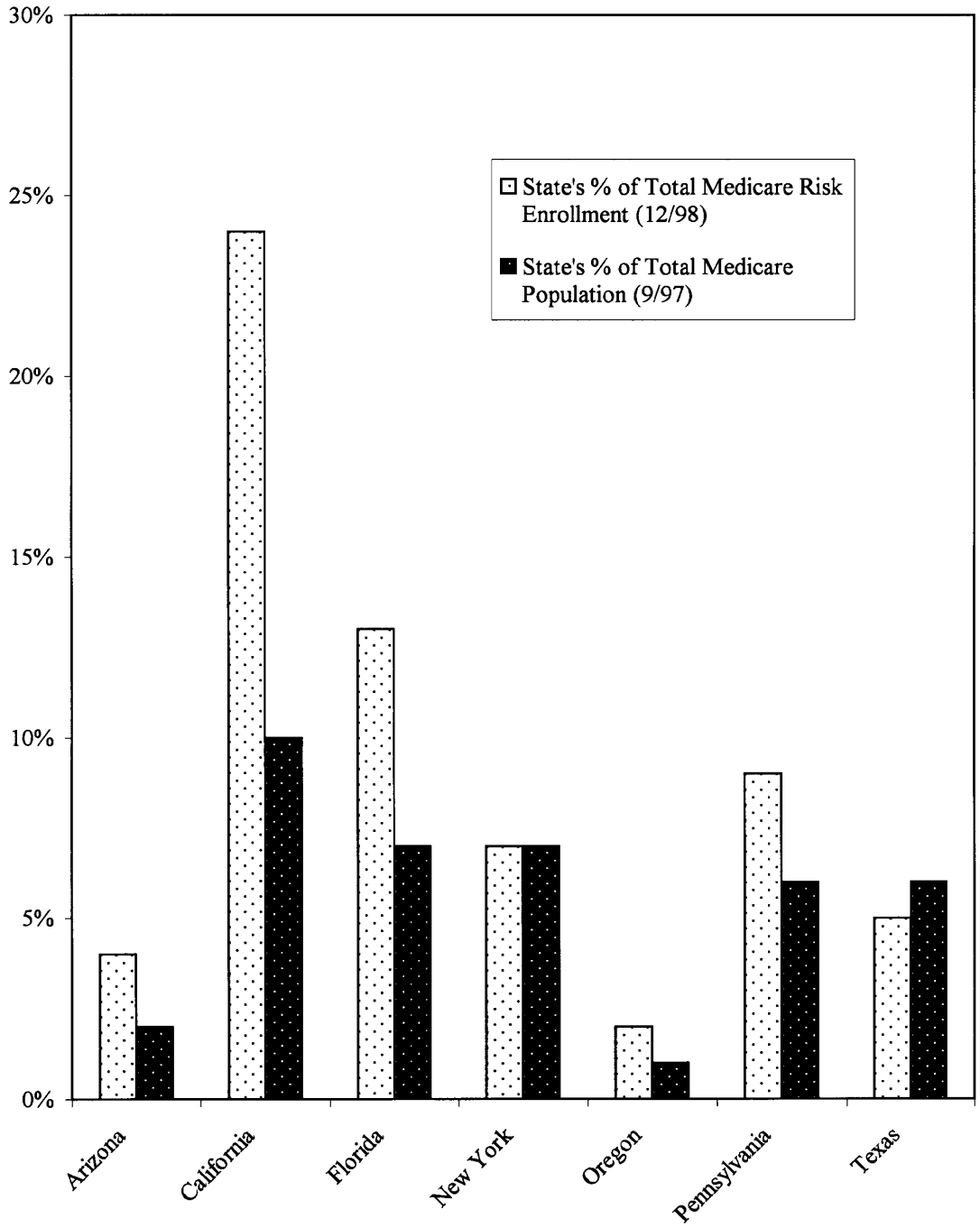
TABLE 4.7. Distribution of Medicare Risk HMO Enrollees Among Selected States, 1998

(in percent)

State	Total Risk Enrollment (12/98)	Total Medicare Population (9/97)
Arizona	4	2
California	24	10
Florida	13	7
New York	7	7
Oregon	2	1
Pennsylvania	9	6
Texas	5	6

Note: Table prepared by CRS.

Figure 4.7. Distribution of Medicare Risk HMO Enrollees Among Selected States, 1998



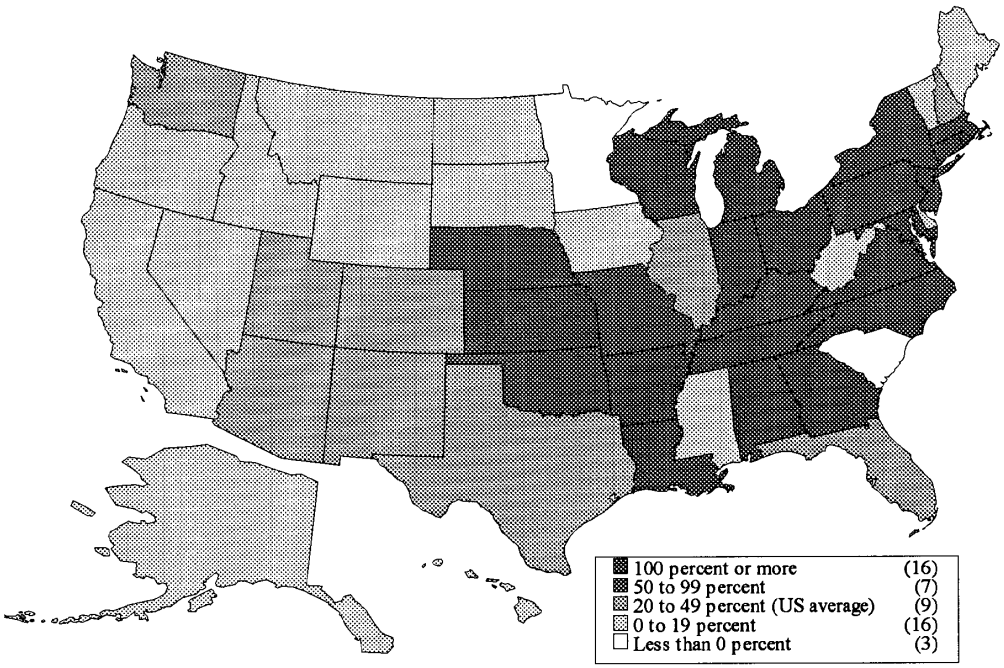
Source: Figure prepared by CRS based on HCFA, *Managed Care Contract Report*, December 1998.

Figure 4.8.
Growth in Medicare Risk HMO Enrollment, December 1996–December 1998 (New Enrollees as a Percent of Previous State Enrollment)

The traditional definition of growth in Medicare risk HMO enrollment was the change in enrollment from one time to another. Using this definition, national growth was almost 50% during the period December 1996 through December 1998. Growth was highest in eastern states, where enrollment levels typically had been low or moderate. Because the base enrollment was quite low in some of these states, even relatively few new enrollees led to large growth rates.

Figure 4.8. Growth in Medicare Risk HMO Enrollment, December 1996-December 1998

New Enrollees as a Percent of Previous State Enrollment



Source: Map prepared by CRS based on HCFA, *Medicare Managed Care Contract Reports.*

Figure 4.9.
Percent of Medicare Beneficiaries Enrolled in Risk HMOs, by Number of Plans Available in Their Area, June 1998

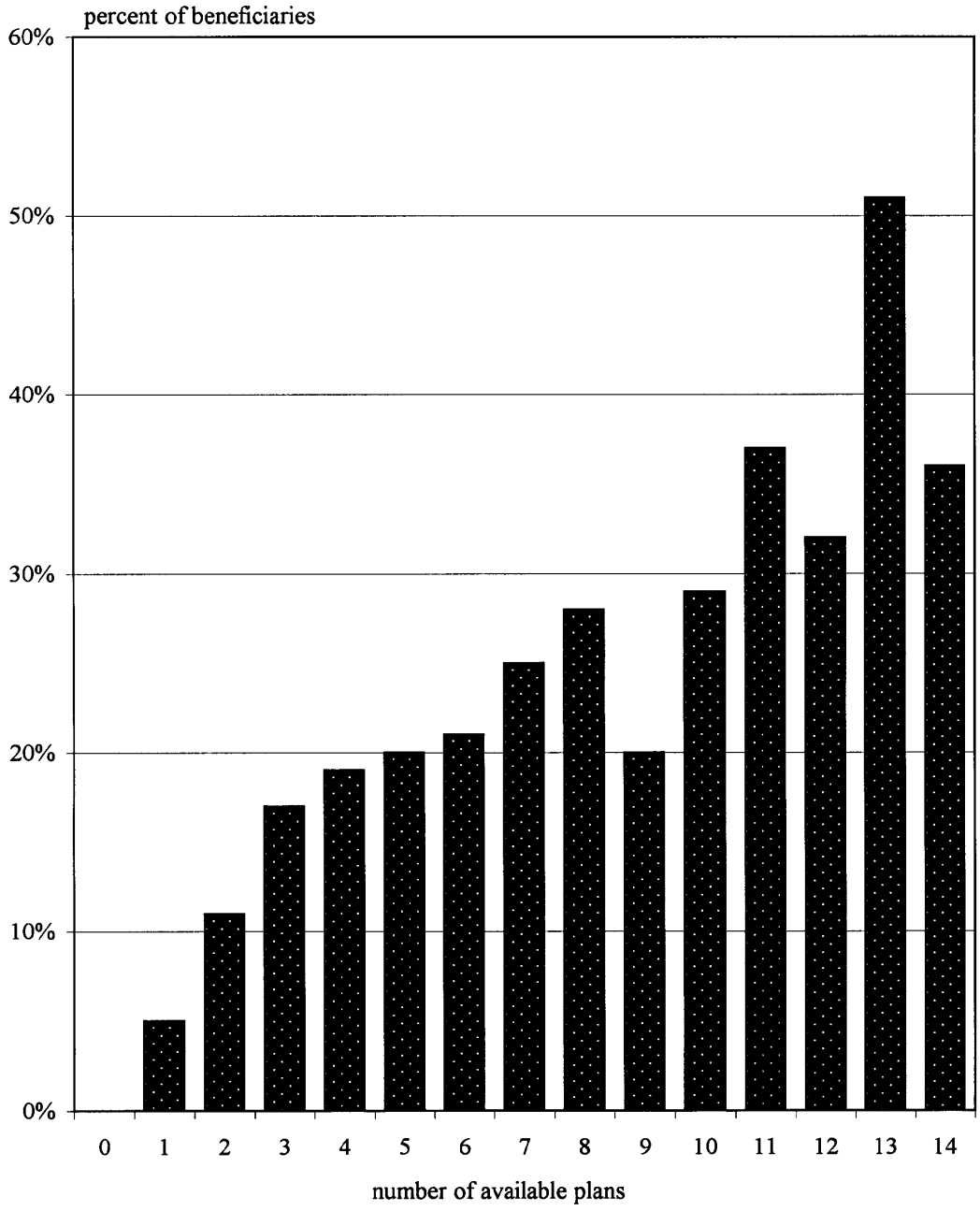
In 1998, 11% or fewer of beneficiaries with two or fewer plans available had enrolled in a risk HMO. In contrast, areas in which eleven or more risk HMOs were available enrolled over one-third of all beneficiaries, on average.

TABLE 4.9. Percent of Medicare Beneficiaries Enrolled in Risk HMOs, by Number of Plans Available in Their Area, June 1998

Number of Plans Available	Percent of Beneficiaries Enrolled
0	0.0
1	5.0
2	11.0
3	17.0
4	19.0
5	20.0
6	21.0
7	25.0
8	28.0
9	20.0
10	29.0
11	37.0
12	32.0
13	51.0
14	36.0

Note: Table prepared by CRS based on MedPAC analysis of HCFA data.

Figure 4.9. Percent of Medicare Beneficiaries Enrolled in Risk HMOs, by Number of Plans Available in Their Area, June 1998



Source: Figure prepared by CRS based on MedPAC *Chart Book*, July 1998, Chart 2-7.

Figure 4.10.
Medicare Risk Contract Plan Terminations, 1985–1998

The early years of the Medicare risk program saw substantial turnover in the number of HMOs participating in Medicare. In the past few years, more and more HMOs entered the Medicare risk market and contract terminations declined. Prior to 1998, terminations reached a high of 38 plans in 1989, declining to fewer than 5 annually from 1993 through 1997.

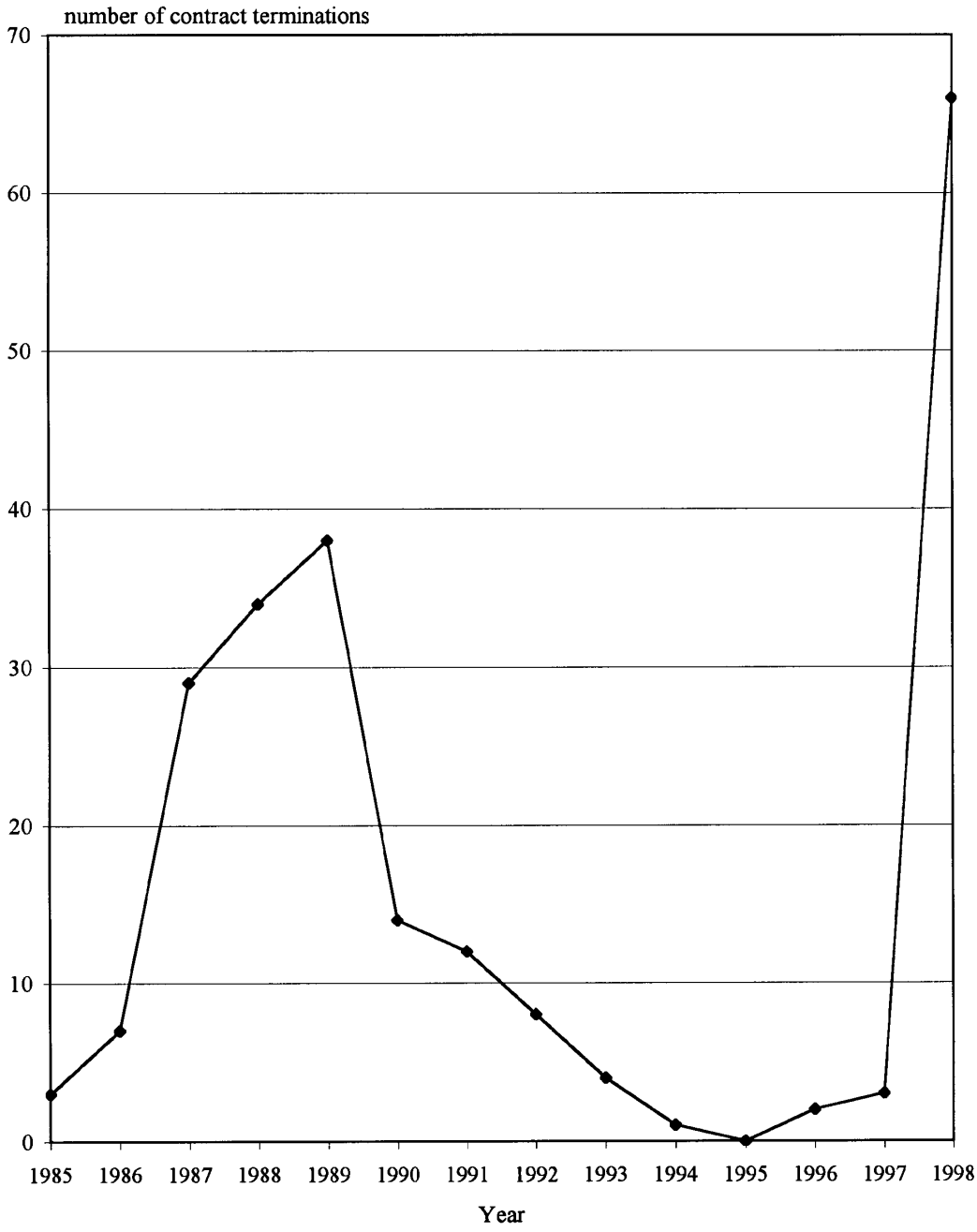
Immediately prior to the beginning of the Medicare+Choice program in January 1999, a number of plans withdrew from the Medicare risk program or reduced the size of their service areas. These plans terminated 66 contracts at the end of 1998. These changes affected slightly more than 400,000 (6.5%) of the more than 6 million Medicare beneficiaries enrolled in managed care. Slightly more than 50,000 beneficiaries, less than 1% of Medicare risk enrollees, were left without access to another managed care plan. In total, 372 counties were affected by the withdrawals or service area reductions; 72 counties lost access to Medicare managed care. Despite these reductions, in February, 28 Medicare+Choice plans had pending applications.

TABLE 4.10. Medicare Risk Contract Plan Terminations, 1985–1998

Year	Contract Terminations
1985	3
1986	7
1987	29
1988	34
1989	38
1990	14
1991	12
1992	8
1993	4
1994	1
1995	0
1996	2
1997	3
1998	66

Note: Table prepared by CRS.

Figure 4.10. Medicare Risk Contract Plan Terminations, 1985-1998



Source: HCFA, *A Profile of Medicare Chart Book*, 1998; HCFA, *Non-Renewal and Service Area Reduction Information*, 1999.

Figure 4.11.
Medicare Risk HMO Contracts by Plan Model, December 1998

The majority of Medicare risk HMOs were independent practice associations (IPAs). An IPA is an HMO that contracts with physicians in solo practice or with associations of physicians that, in turn, contract with their member physicians to provide health care services. Many physicians in IPA HMOs have a significant number of patients who are not IPA enrollees. Group model HMOs contract with one or more group practices of physicians to provide health care services, and each group primarily treats the HMO's members. Staff model HMOs employ health providers, such as physicians and nurses, directly. The providers are employees of the HMO, and deal exclusively with HMO enrollees.

Sixty-six percent of Medicare beneficiaries enrolled in a Medicare HMO in 1998 were in an IPA model plan.

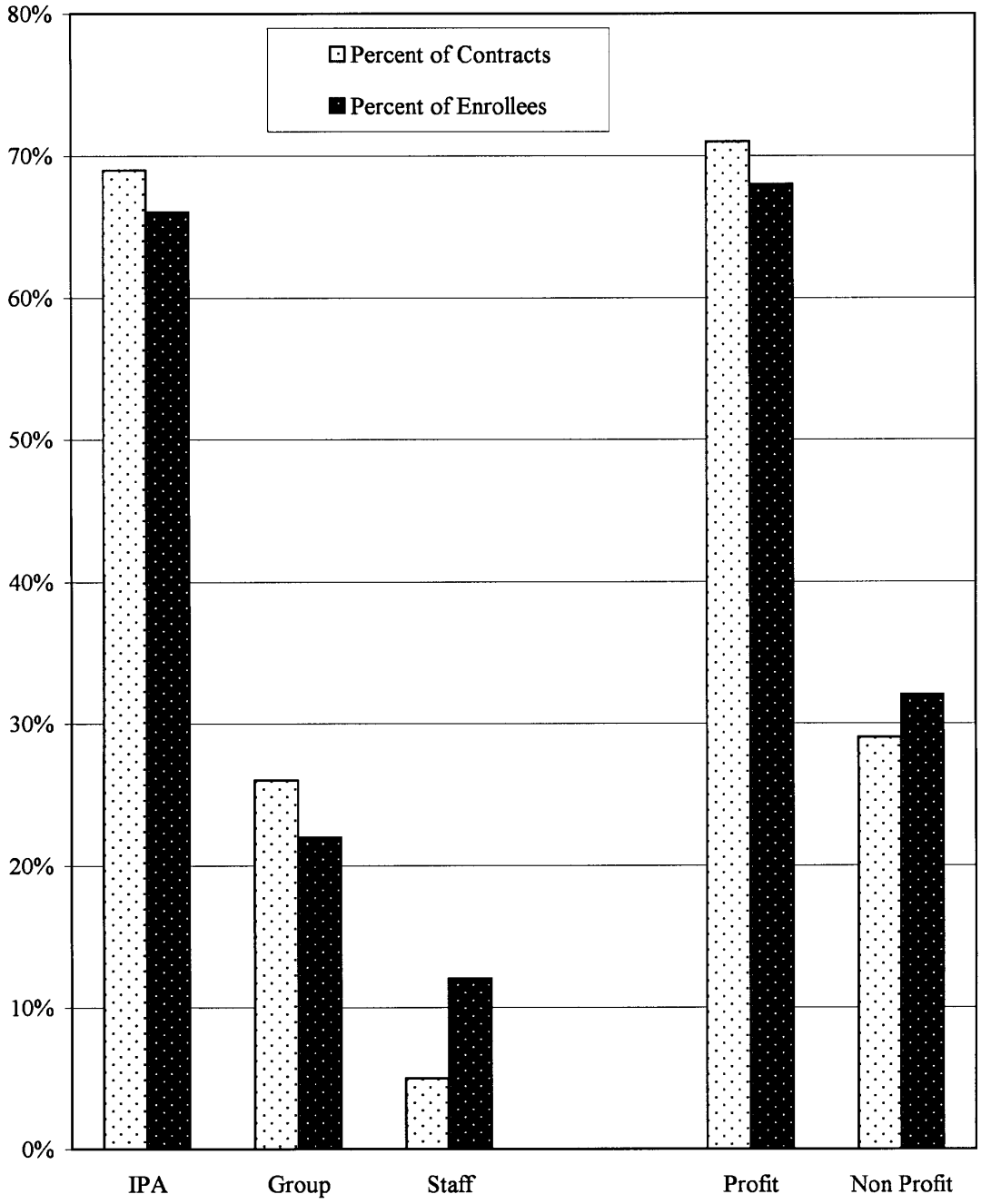
Most risk contract plans (71%) were owned by for-profit managed care organizations. These plans enrolled 68% of Medicare's risk plan membership.

TABLE 4.11. Medicare Risk HMO Contracts by Plan Model, December 1998

	Number of Contracts	Percent of Contracts	Number of Enrollees	Percent of Enrollees
Model				
IPA	237	69%	4,021,395	66%
Group	90	26%	1,358,224	22%
Staff	18	5%	675,005	12%
Ownership				
Profit	247	71%	4,118,303	68%
Non profit	99	29%	1,937,243	32%

Note: Table prepared by CRS.

Figure 4.11. Medicare Risk HMO Contracts by Plan Model, December 1998

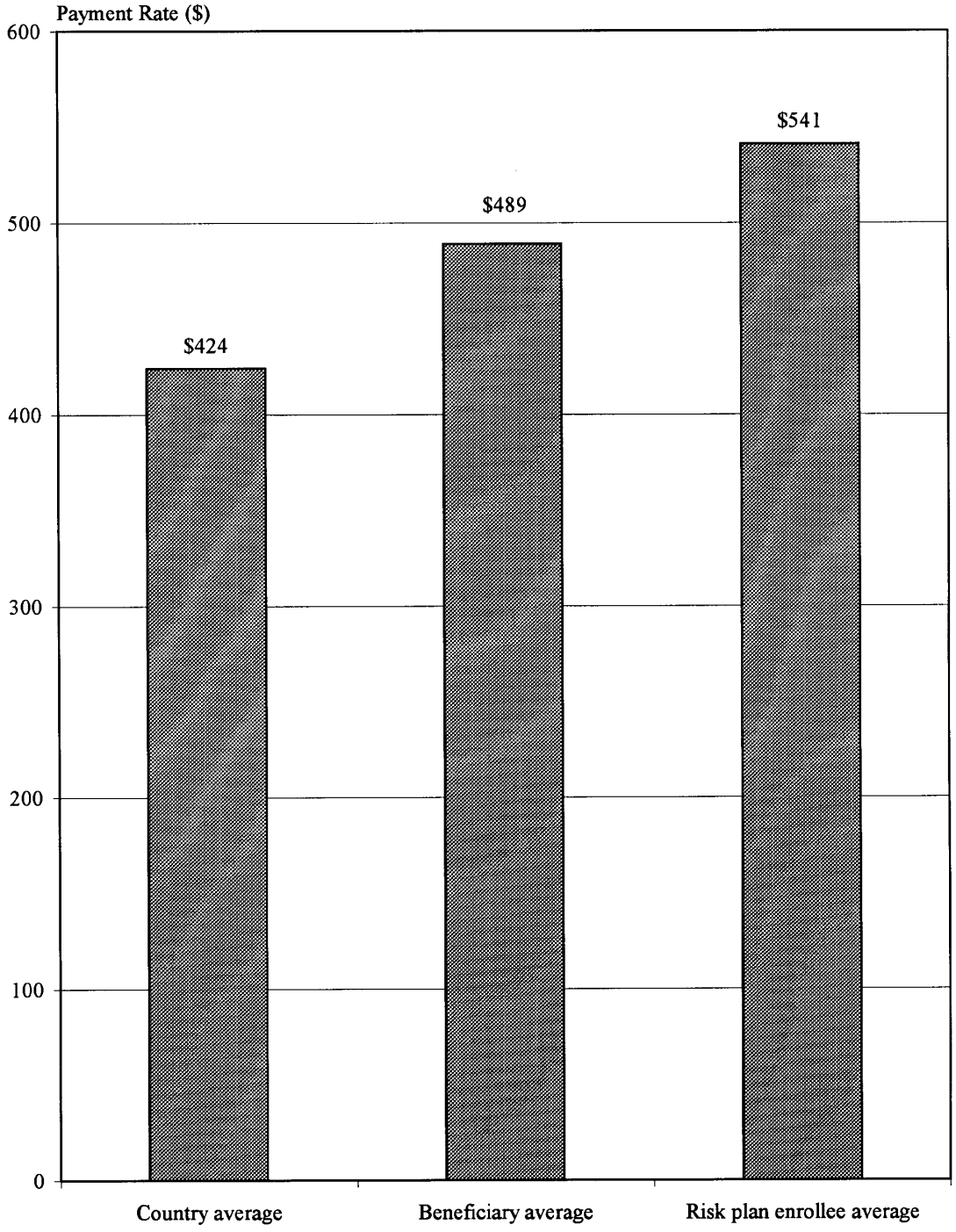


Source: Figure prepared by CRS based on HCFA, *Medicare Managed Care Contract Report*, December 1998.

Figure 4.12.
Average Monthly Medicare+Choice Payment Rate for Aged Beneficiaries, 1999

In 1999, the average county has a monthly payment rate of $424 for aged beneficiaries, while the average Medicare beneficiary lives in a county with a payment rate of $489. This difference occurs because payment rates are generally higher in more populous counties. The average Medicare+Choice enrollee lives in a county with a payment rate of $541. This higher rate indicates that enrollees tend to live in counties with higher payment rates.

Figure 4.12. Average Monthly Medicare+Choice Payment Rate for Aged Beneficiaries, 1999



Source: CRS analysis of HCFA data.

Figure 4.13.
Medicare+Choice Budget Neutrality Provision Eliminates Blend from 1998 and 1999 HMO Payments

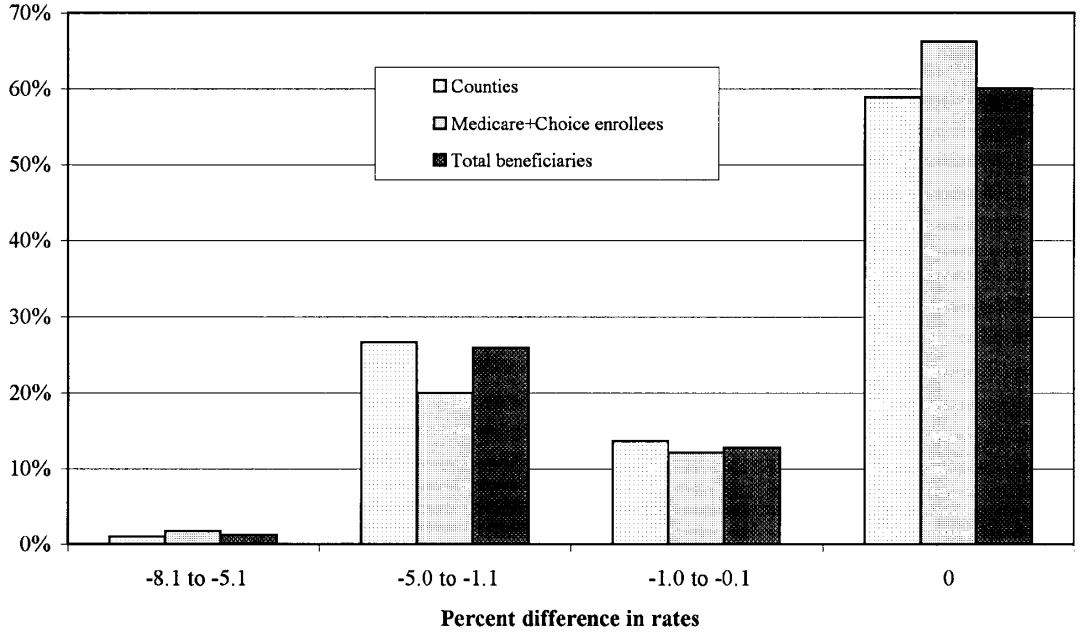
Under the Balanced Budget Act of 1997 (BBA), payment rates to capitated plans are set at the county level. A county's Medicare+Choice rate is the maximum of three different rates:

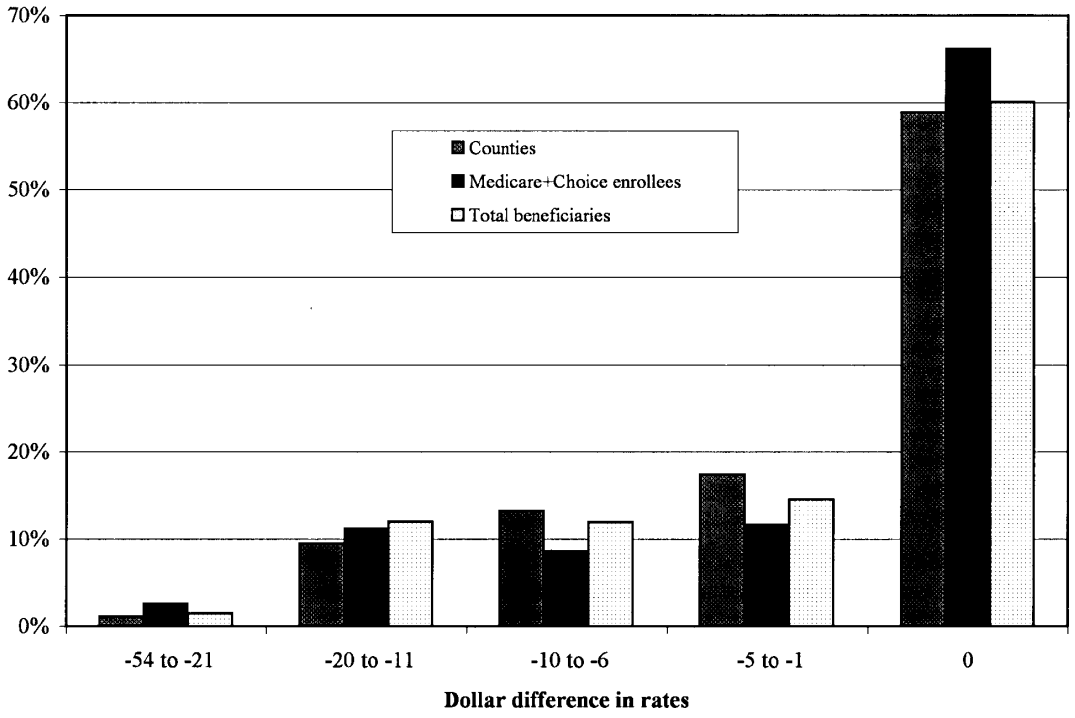
- a floor, equal to $367 per month in 1998 and $380 per month in 1999 for the 50 states and D.C., updated annually by the national growth percentage;
- a "minimum update" equal to the previous year's payment rate increased by 2%; and
- a "blend" equal to a combination of local area-specific (i.e., county) and national, input-price adjusted rates.

In both 1998 and 1999, no U.S. counties receive a blend rate. This outcome results from the budget neutrality provision of the BBA (Section 1853(d)(3)(B)), which requires that Medicare+Choice payments not exceed payments that would have been made if payments were based solely on local rates. If awarding the county the maximum of the three rates would exceed the budget neutral target, counties which would otherwise receive the blend rate have their rates reduced to meet the target. The rate may not fall below the greater of the county's floor or minimum update. Counties originally at the floor or minimum update do not have their rates reduced.

The budget neutrality provision reduces Medicare+Choice rates for aged beneficiaries in 1,293 counties (41%) in 1999. These counties would have received blend amounts if sufficient funds were available to fund all counties at the maximum of the floor, blend, or minimum update. Actual 1999 rates were compared to rates that would have occurred without budget neutrality. The figure shows that over half (59%) of all counties, which include two-thirds (66%) of all Medicare+Choice enrollees and 60% of all Medicare beneficiaries, have no differences in Medicare+Choice payments due to the budget neutrality provision. These counties receive either the floor or minimum update with or without the budget neutrality provision. Virtually all counties (99%) and Medicare+Choice enrollees (98%) have actual rates that are the same or include reductions of 5% or less. Looking at dollar amounts, the figure shows that over three-fourths of counties (76%) and of Medicare+Choice enrollees (78%) had monthly rates reduced by $5 or less. Only 1% of counties and 3% of Medicare+Choice enrollees had monthly rates reduced by more than $20 due to the budget neutrality provision.

Figure 4.13. Medicare+Choice Budget Neutrality Provision Eliminates Blend from 1998 and 1999 HMO Payments





Source: CRS Report 98-867, *Medicare's Budget Neutrality Provision Eliminates Blend from 1998 and 1999 HMO Payments*, by Madeleine Smith.

Figure 4.14.
Spread of County Medicare+Choice Payments for the Aged by Location, 1997–1999

Medicare pays HMOs and other private plans that contract with Medicare a fixed monthly payment for each Medicare beneficiary enrolled in the plan. Beginning in 1998, this Medicare+Choice payment is calculated by the formula in the Balanced Budget Act (BBA) of 1997.

Under the BBA, a county's payment rate is the largest of three different rates:

- a "floor," or minimum payment rate;
- a "minimum update" rate, which is 2% higher than the previous year's rate; and
- a "blended" rate.

In 1998 and 1999, each county receives the higher of the floor or minimum update rate because of the budget neutrality provision in the BBA.

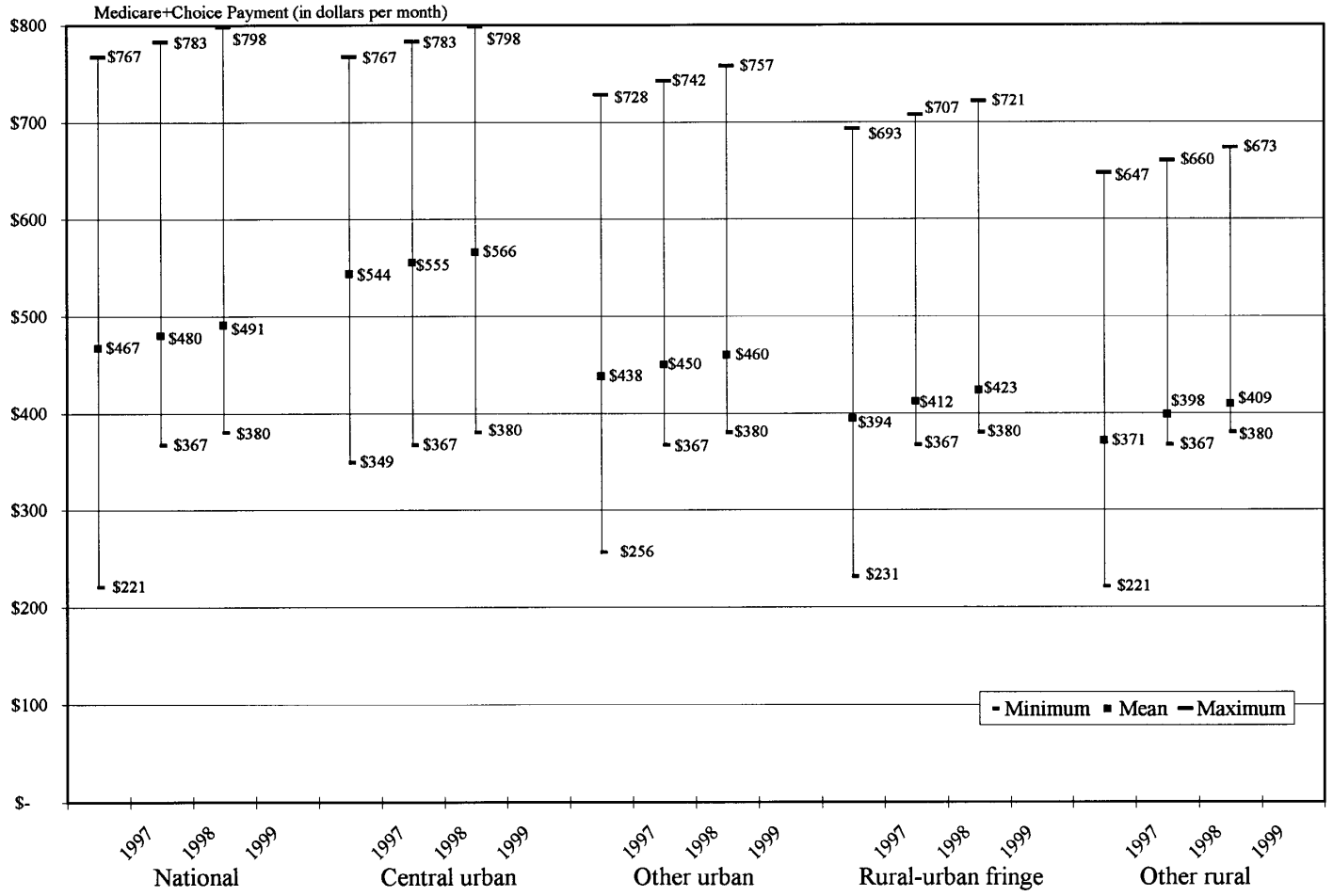
Medicare pays a range of rates for enrollees in different counties across the United States. Nationally, this range has narrowed from $546 in 1997 to $416 in 1998 and $418 in 1999. On average, rates are higher in urban areas than in rural areas, but the difference between mean rates in "central urban" and "other rural" areas has narrowed—from $173 in 1997 to $157 in 1998 and 1999. However, there is also a wide range of variation for rates even within urban and rural areas. For example, the lowest rate per month for 1999 in "urban" areas will be $380, while the highest rate for these areas will be $798, which is over twice as much.

TABLE 4.14. Spread of Medicare+Choice Payments for the Aged by Location, 1997–1999

		Minimum	Mean	Maximum
1997				
	National	$221	$467	$767
	Central urban	349	544	767
	Other urban	256	438	728
	Rural-urban fringe	231	394	693
	Other rural	221	371	647
1998				
	National	$367	$480	$783
	Central urban	367	555	783
	Other urban	367	450	742
	Rural-urban fringe	367	412	707
	Other rural	367	398	660
1999				
	National	$380	$491	$798
	Central urban	380	566	798
	Other urban	380	460	757
	Rural-urban fringe	380	423	721
	Other rural	380	409	673

Note: Table prepared by CRS based on analysis of HCFA data. Means weighted by the number of aged beneficiaries per county in 1996.

Figure 4.14. Spread of County Medicare+Choice Payments for the Aged by Location, 1997-1999



Source: Figure prepared by CRS based on analysis of HCFA data.
Note: Means weighted by the number of aged beneficiaries per county in 1996.

Figure 4.15.
Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package, December 1997 and December 1998

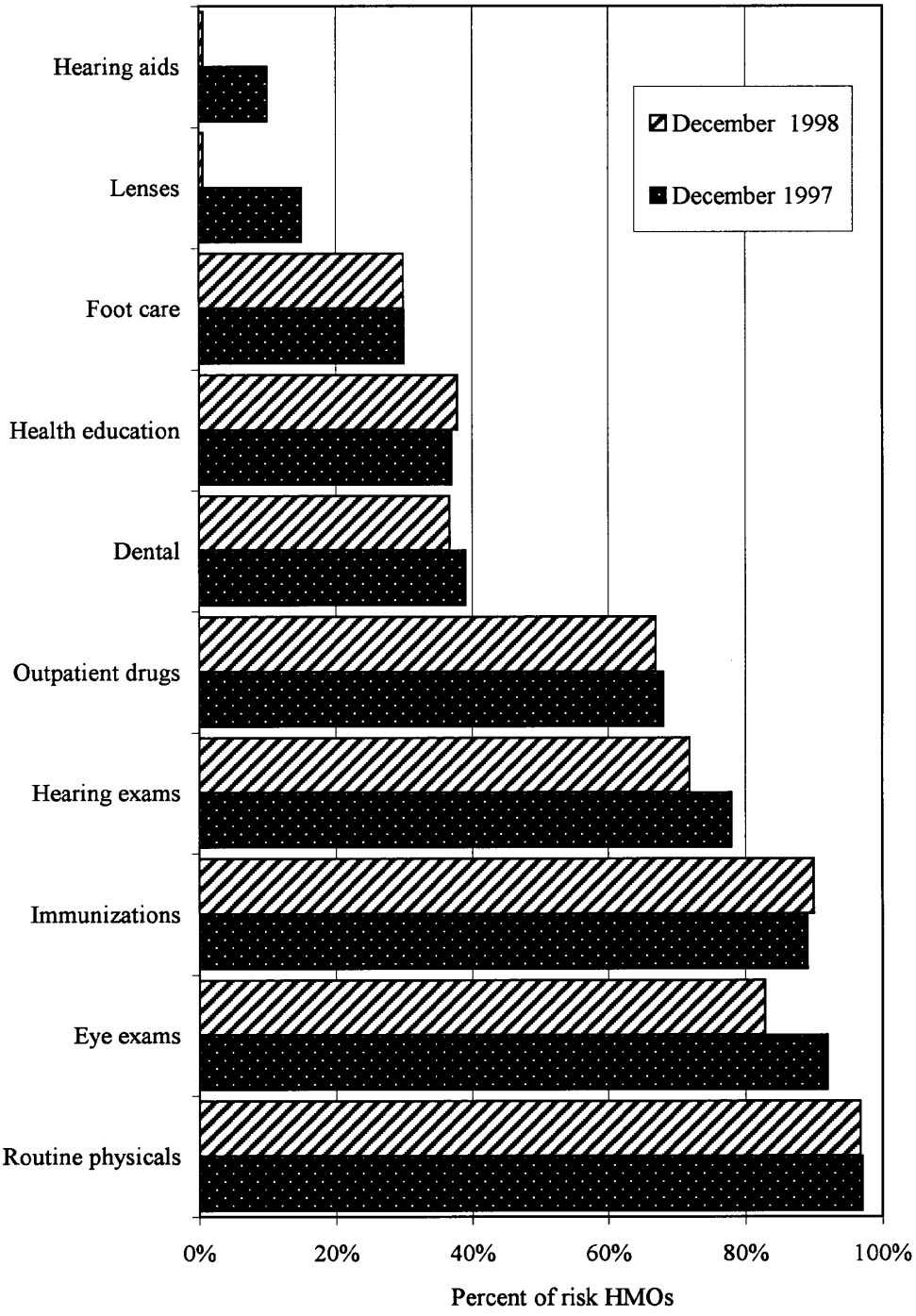
Most Medicare enrollees in risk HMOs were provided with additional services not covered by traditional Medicare. For example, in December 1997, 92% of Medicare risk plans offered eye exams as part of their basic benefit package, 97% offered routine physicals, and 68% offered some coverage of prescription (outpatient) drugs. Similar levels of coverage were reported in December 1998 for many services, although declines were reported for eye and hearing exams and large declines for glasses and hearing aids. Note that these figures only apply to basic option packages. Data are not available for coverage under high option packages. The percentage of plans covering prescription drugs has varied over time. In December 1995, only 50% of risk plans offered such coverage, compared to 78% of plans in January 1997, 68% in December 1997 and 67% in December 1998.

TABLE 4.15. Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package

Benefit	Percent of Risk HMOs	
	December 1997	December 1998
Routine physicals	97	97
Eye exams	92	83
Immunizations	89	90
Hearing exams	78	72
Outpatient drugs	68	67
Dental	39	37
Health education	37	38
Foot care	30	30
Lenses	15	1
Hearing aids	10	1

Note: Table prepared by CRS.

Figure 4.15. Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package, December 1997 and December 1998



Source: Figure prepared by CRS from HCFA, *Medicare Managed Care Report*, Dec. 1997 and Dec. 1998.

Figure 4.16.
Distribution of Medicare Risk HMOs by Premium Charged, 1996–1998

Different Medicare risk HMOs charged different premiums to enrollees. The majority of risk HMOs (70% in December 1998) required enrollees to pay no premium above and beyond the Medicare Part B premium for the plan's basic benefit package ($43.80 in 1998; $45.50 in 1999). In 1998, almost 1 in 5 plans charged a monthly premium of $40 or more for their basic package, compared to 1 in 10 in 1997, and 1 in 6 in 1996. The proportion of zero-premium plans increased by 4.7% from December 1996 to December 1997, but by less than 1% from December 1997 to December 1998. Data are not available for premiums charged for high option packages.

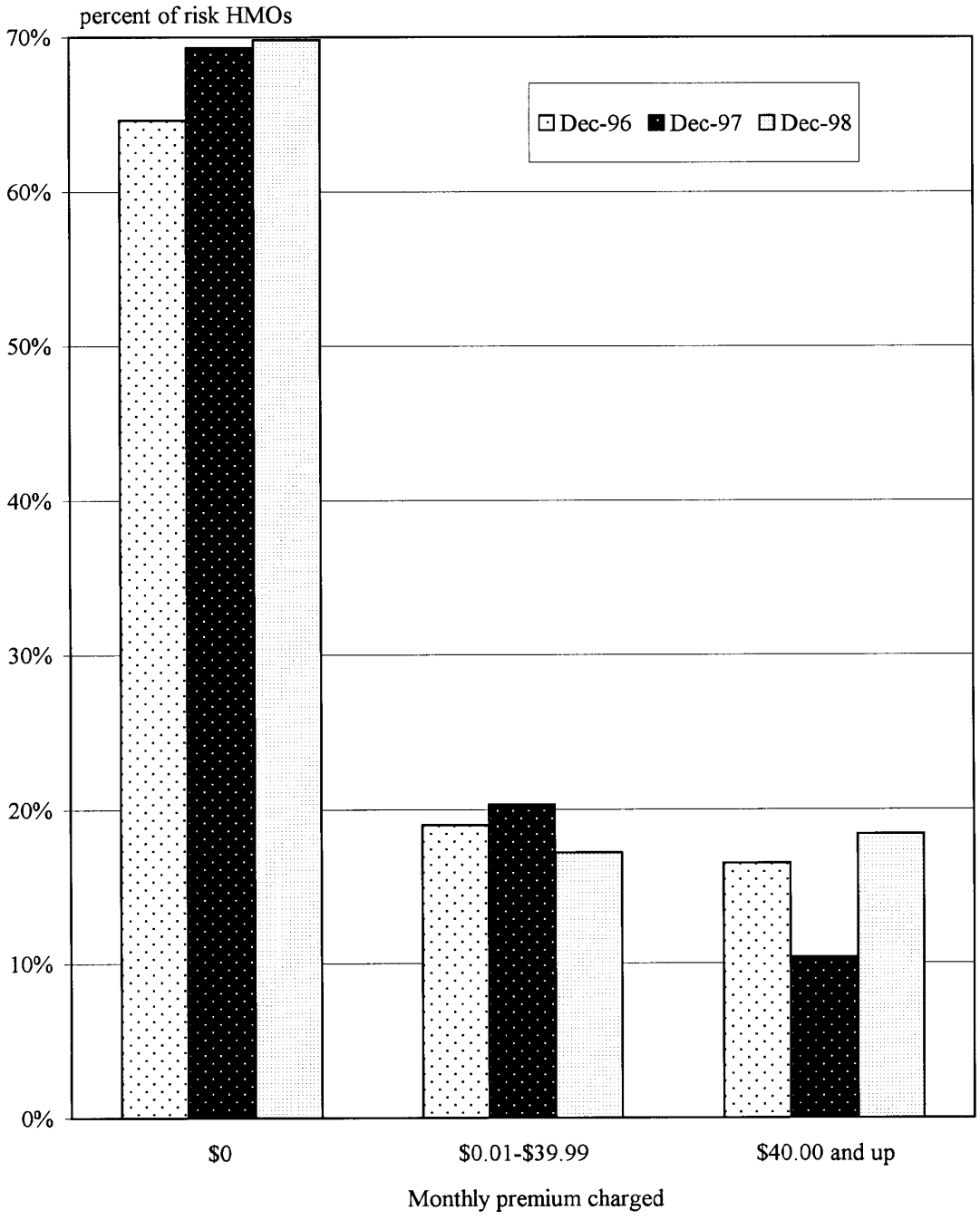
TABLE 4.16. Distribution of Medicare Risk HMOs by Premium Charged for Basic Option Package, 1996–1998

(in percent)

In Addition to Medicare Monthly Premium	December 1996	December 1997	December 1998
$0	64.6	69.3	69.8
$0.01–$39.99	19.0	20.3	17.2
$40.00 and up	16.5	10.4	18.4

Note: Table prepared by CRS.

Figure 4.16. Distribution of Medicare Risk HMOs by Premium Charged, 1996-1998



Source: Figure prepared by CRS from HCFA, *Medicare Managed Care Contract Report*, Dec. 1996, Dec. 1997, and Dec. 1998.

Figure 4.17.
Age, Income and Health Status of Medicare HMO Enrollees versus Medicare Fee-for-Service Enrollees

Individuals entitled to Medicare on the basis of disability (those under 65 years old) were less likely to be enrolled in Medicare risk HMOs than in fee-for-service (FFS). The likelihood of being enrolled in a risk HMO was highest for beneficiaries aged 65 to 74. The least wealthy and most wealthy Medicare beneficiaries were disproportionately under-represented in HMO enrollment. In contrast, those with reported income between $10,000 and $50,000 were somewhat over-represented in HMOs, compared to the distribution of beneficiaries in traditional Medicare.

According to HCFA's analysis of the 1996 Medicare Current Beneficiary Survey, Medicare beneficiaries enrolled in risk HMOs were healthier than those in the fee-for-service program. For example, 84% of risk HMO enrollees needed no assistance with activities of daily living (ADLs) compared with about 75% of beneficiaries in Medicare fee-for-service. About 50% more fee-for-service beneficiaries reported that their health was fair or poor than risk HMO enrollees. This may reflect a variety of factors. Healthier beneficiaries may be more likely to enroll in risk HMOs. It is also possible that enrollees in risk HMOs might have relatively better access to care.

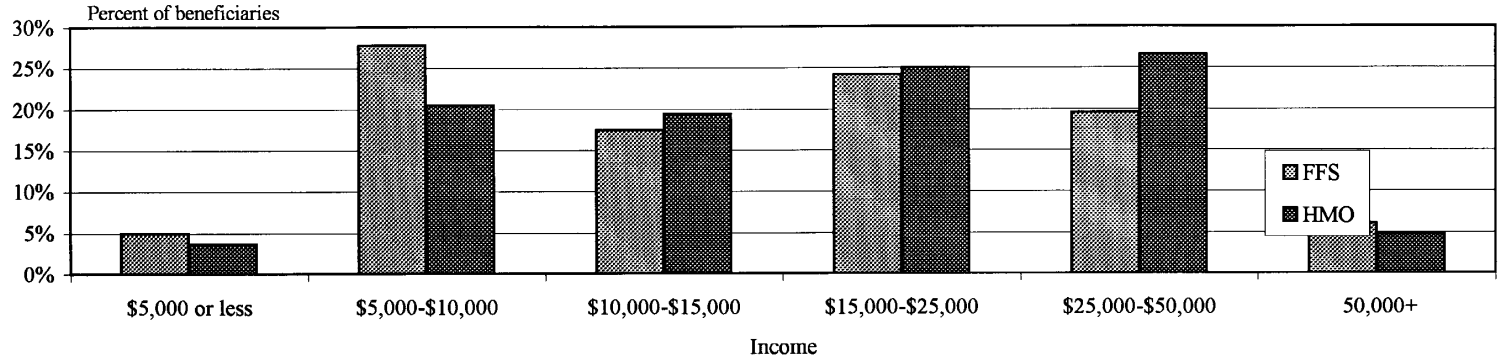
TABLE 4.17. Age, Income and Health Status of Medicare HMO and FFS Enrollees

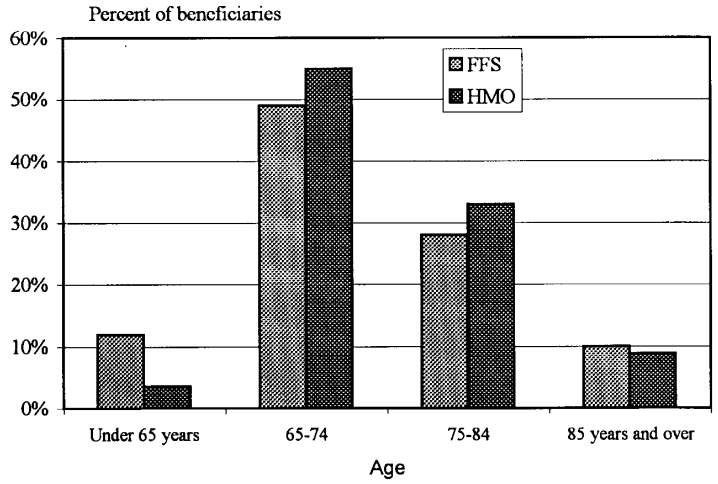
(in percent)

	Percent of FFS Population	Percent of HMO Enrollment
Age, 1995		
Under 65 years	12.0	3.6
65–74	49.0	55.0
75–84	28.0	33.0
85 years and over	10.0	8.8
Income, 1995		
$5,000 or less	5.0	3.7
$5,000–$10,000	27.8	20.5
$10,000–$15,000	17.4	19.4
$15,000–$25,000	24.2	25.0
$25,000–$50,000	19.5	26.6
$50,000+	6.0	4.8
Relative health status, 1996		
No ADL assistance	75.3	84.0
Three or more ADLs	11.7	4.9
Health: excellent, very good or good	69.6	80.5
Health: fair or poor	30.1	19.4

Note: Table prepared by CRS.

Figure 4.17. Age, Income and Health Status of Medicare HMO Enrollees versus Medicare Fee-for-Service Enrollees





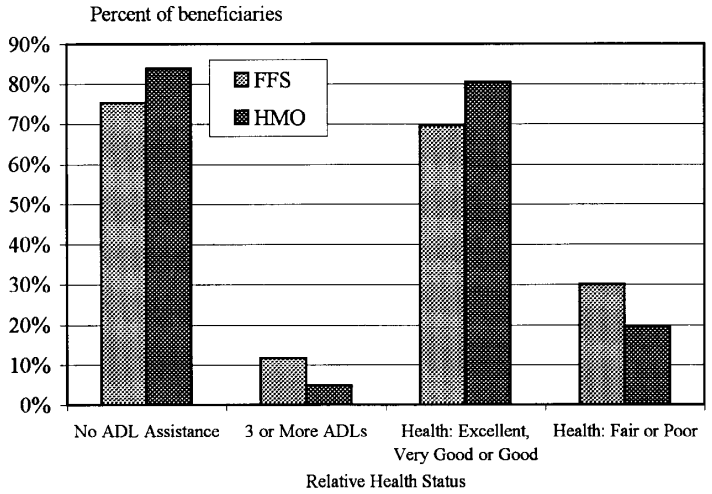
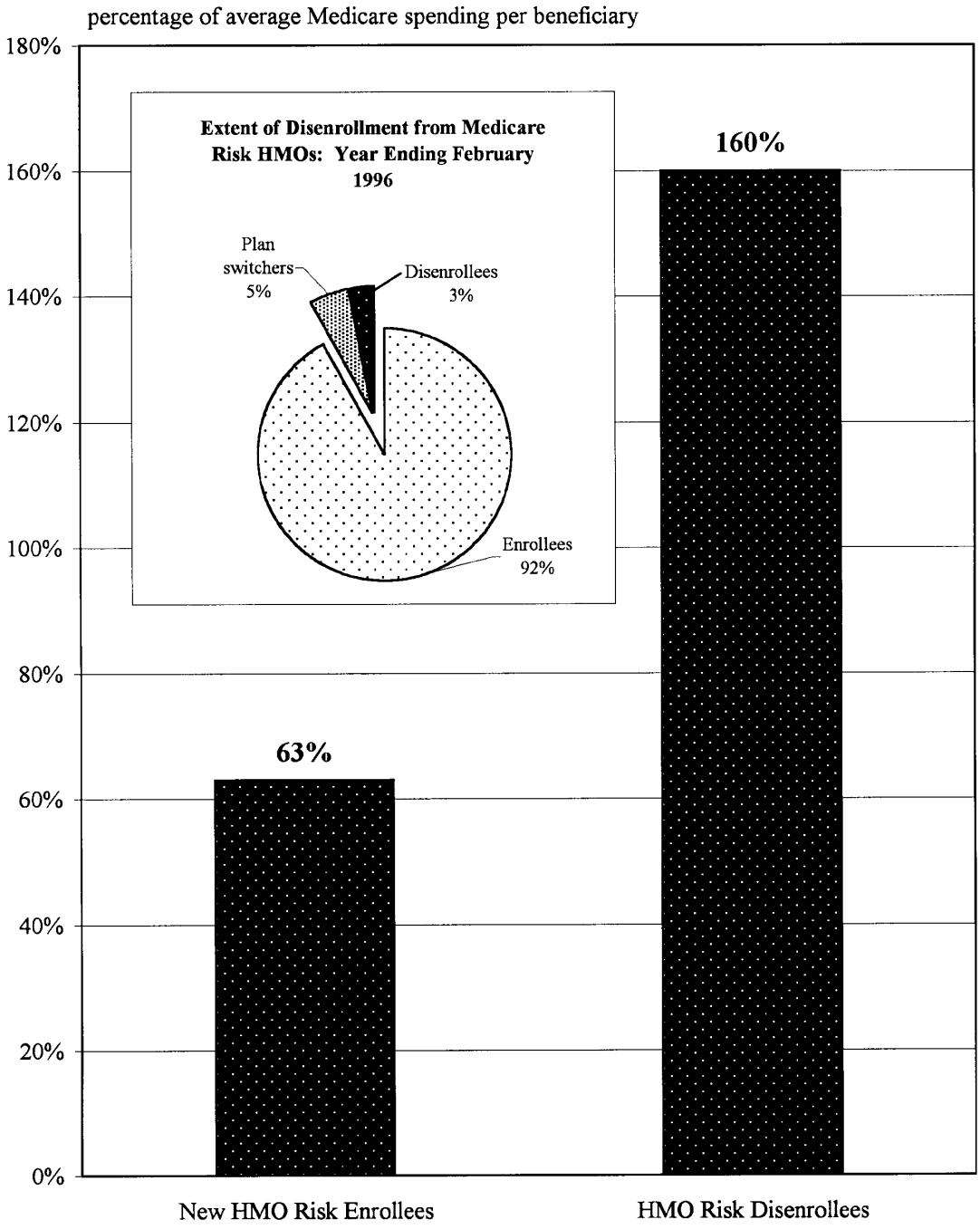


Figure 4.18.
Medicare Risk HMOs: Costs as a Percentage of Average Medicare Spending Per Beneficiary

Several studies have found that Medicare beneficiaries who enrolled in HMOs used fewer Medicare-covered services than those who remained in the fee-for-service program. Such differences were also reflected in studies that showed that Medicare beneficiaries who enrolled in HMOs had relatively low costs prior to enrollment. Using data through mid–1994, the Physician Payment Review Commission (PPRC) found that new HMO enrollees' costs were 37% below average Medicare spending per beneficiary during the 6 months prior to HMO enrollment. Moreover, as shown in the figure, beneficiaries who enrolled and then disenrolled from an HMO (and returned to fee-for-service) had costs that were 60% above the average expenditure for fee-for-service individuals. However, it should be noted that within the 1 year period ending February 1996, the vast majority (97%) of HMO enrollees did not disenroll. (As shown in the inset, 3% of beneficiaries disenrolled and 5% switched from one HMO to another.)

Figure 4.18. Medicare Risk HMOs: Costs as a Percentage of Average Medicare Spending Per Beneficiary



Source: Figure prepared by CRS based on PPRC, *Evidence of Risk Selection in Medicare HMOs*, No. 1, October 1996, Figure 1, p. 1; and Update No. 4, 1996.

Figure 4.19.
Current Risk Adjustment of Medicare+Choice Payments, 1999

HCFA currently uses five demographic characteristics of beneficiaries to "risk adjust" payment rates to Medicare+Choice providers: age, gender, eligibility for Medicaid, working status, and institutionalized status. Most agree that these demographic factors do not capture much of the variation in Medicare beneficiaries' medical care costs. Beginning in 2000, HCFA will implement a new risk adjustment mechanism based on diagnoses of beneficiaries with an inpatient hospitalization, the principal inpatient diagnostic cost group (PIP–DCG) model.

In general, the five demographic factors assume that younger beneficiaries, females, non-Medicaid recipients, working aged, and non-institutionalized beneficiaries are less costly. Using these factors, the least costly beneficiary would be a female, aged 65 to 69, who is still working, not receiving Medicaid, and not institutionalized. The most costly beneficiary would be a male, aged 85 or older, who receives Medicaid, but is not institutionalized, and is not working.

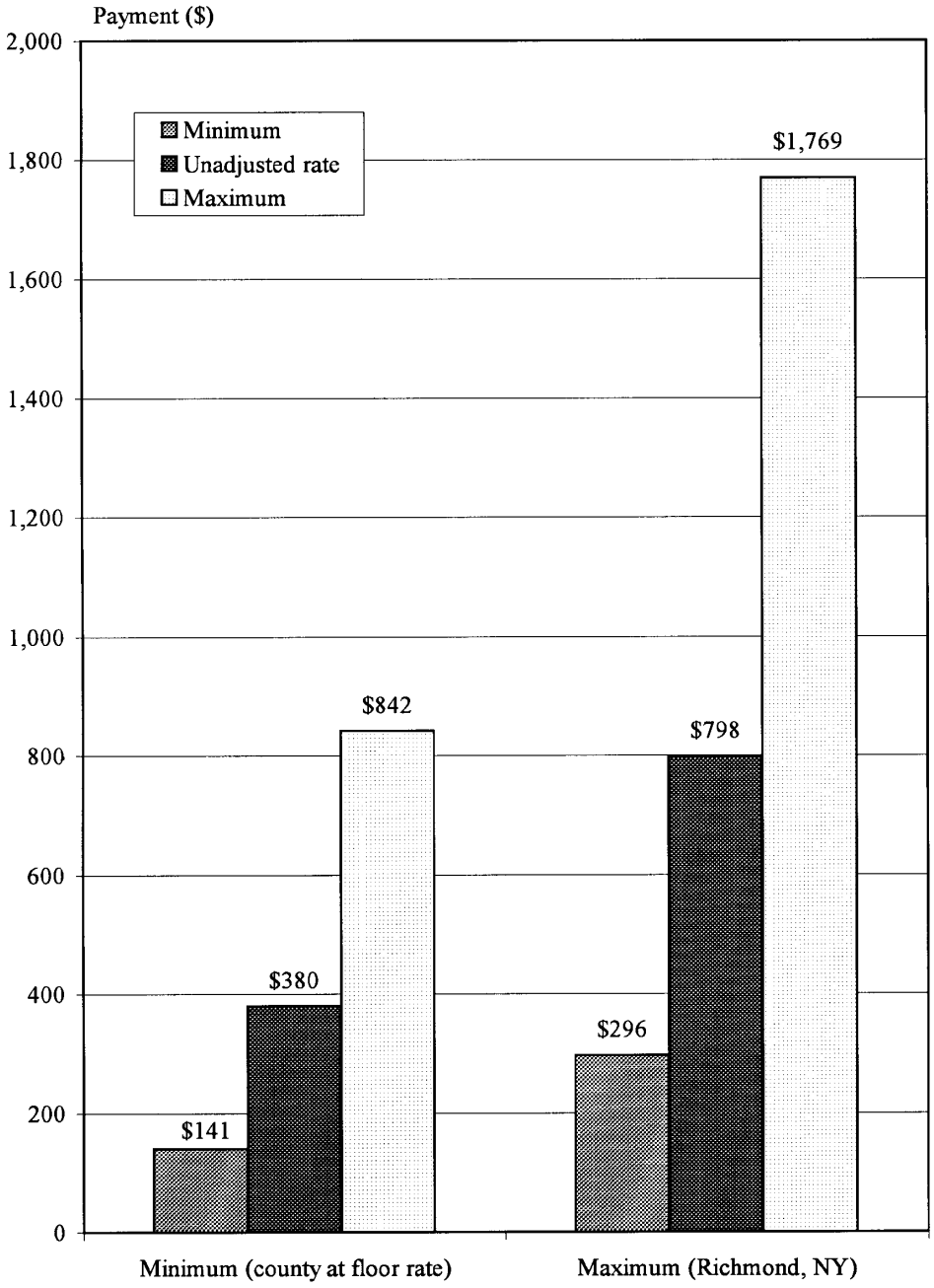
Under the current system, the most costly beneficiary has a demographic adjustment factor that is almost six times greater than the factor for the least costly beneficiary. As a result of demographic risk adjustments, Medicare+Choice providers receiving the minimum Medicare+Choice payment rate in 1999 (i.e., those in counties eligible for the floor payment of $379.84) could see actual payments range from a low of $141 to a high of $842. Medicare+Choice providers in the county with the highest payment rate (i.e., $798.35 in Richmond, NY) could see actual payments range from a low of $296 to a high of $1,769. Actual rates will depend on characteristics of individual enrollees.

TABLE 4.19. Risk Adjustment under Medicare+Choice, 1999

	Actual Unadjusted Rate	Rate for "Best" Risk	Rate for "Worst" Risk
Minimum (county at floor rate)	$380	$141	$ 842
Maximum	$798	$296	$1,769

Source: Table prepared by CRS.

Figure 4.19. Current Risk Adjustment of Medicare+Choice Payments, 1999



Source: Figure prepared by CRS.

Figure 4.20.
Proposed Risk Adjustment of Medicare+Choice Payments, 2000

Beginning in 2000, the Health Care Financing Administration (HCFA) will begin to implement a new risk adjustment mechanism under the Medicare+Choice program. This procedure, the principal inpatient diagnostic cost group, or PIP–DCG, is based on health status factors. Initially, payment will be based on inpatient data using the PIP–DCG adjuster, which predicts incremental costs above the average for a demographic group. The mechanism is prospective; it uses diagnoses in the base year to adjust payment in the following year. HCFA plans to move to comprehensive risk adjustment, based on both inpatient and outpatient data, by 2004.

As of January, 1999, HCFA proposes to use 15 PIP–DCGs to trigger increased payments. Medicare+Choice payments would also be adjusted for age, gender, working status, whether the beneficiary originally qualified for Medicare based on disability, and Medicaid coverage. Separate demographic-based payments would be used for aged persons newly eligible for Medicare, newly disabled Medicare enrollees, and others without a medical history.

The table and figure illustrate calculation of risk factors. Each age and gender group would have a base payment—$4,625 per year for males, aged 75–79, for example. If the enrollee falls into this age/gender group and has no other risk adjustment factors, the overall risk factor would be 0.91 ($4,625/$5,100, with $5,100 the average payment for all Medicare beneficiaries.) An enrollee with a kidney infection admitted to the hospital during the base year would have a payment increment of $5,969 for this diagnosis the following year. With no other risk adjustment factors, this enrollee would have a risk factor of 2.08 ($4,625 + $5,969/$5,100). Similarly, a male with lung cancer, who was originally disabled and received Medicaid benefits, would have a risk factor of 4.14.

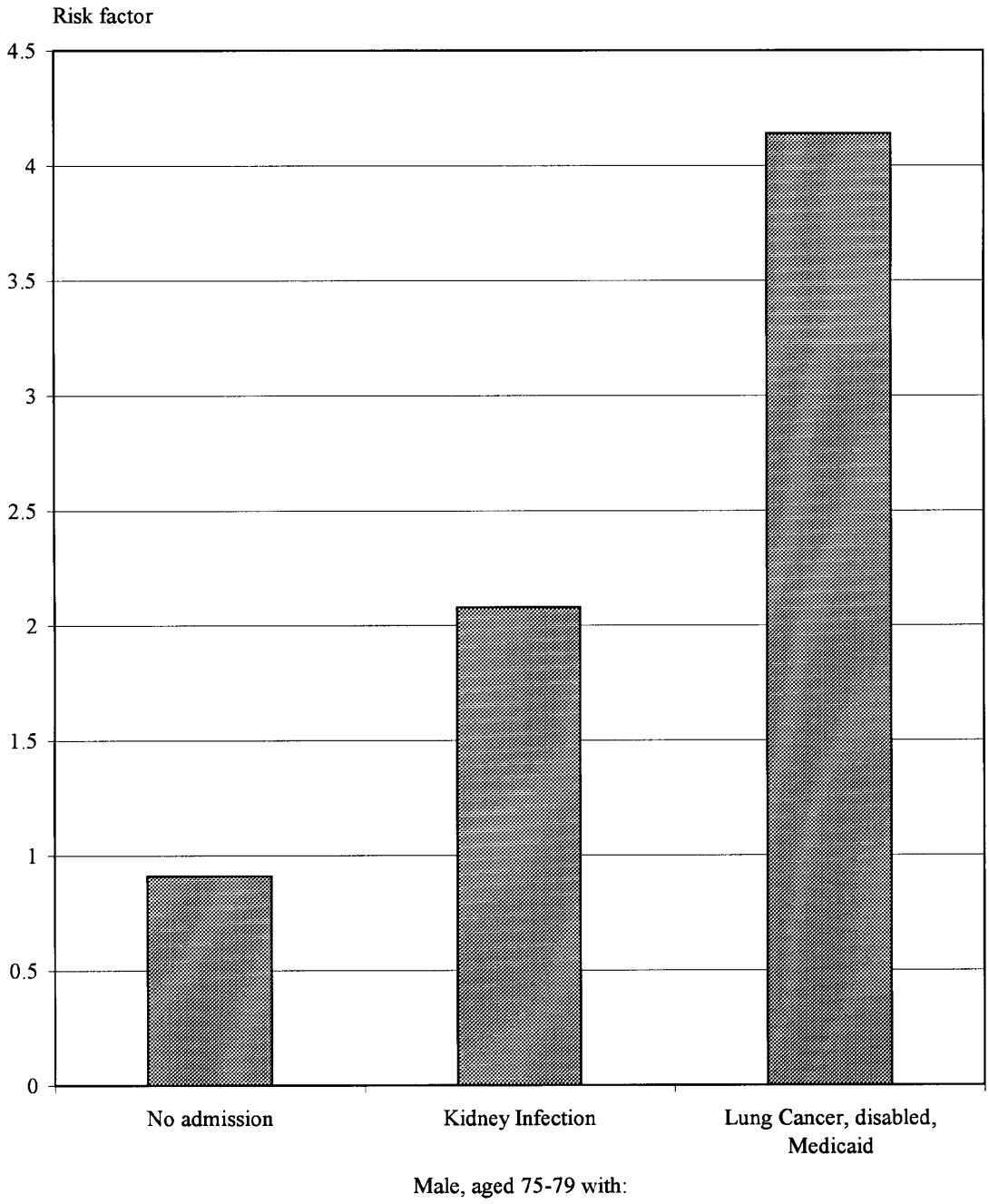
These risk factors would be used to adjust the Medicare+Choice payment rate in effect for the Medicare+Choice provider. HCFA proposes phasing-in the new risk adjustment mechanism, with 90% of the Medicare+Choice rate adjusted for demographic characteristics and 10% for PIP–DCGs in 2000.

Table 4.20. Proposed Risk Adjustment of Medicare+Choice Payments, 2000

	Male 75–79 with: No Admissions	Male 75–79 with: Kidney Infection	Male 75–79 with: Lung Cancer
Base	$4,625	$4,625	$4,625
Health status	0	5,969	12,435
Disabled enrollee	0	0	2,353
Medicaid enrollee	0	0	1,705
Total	4,625	10,594	21,118
Risk factor (total/$5,100)	0.91	2.08	4.14

Source: Table prepared by CRS based on HCFA, Medicare+Choice Risk Adjustments, January 1999.

Figure 4.20. Proposed Risk Adjustment of Medicare+Choice Payments, 2000



Source: Figure prepard by CRS based on HCFA, *Medicare+Choice Risk Adjustments*, January 1999.

Figure 4.21.
Beneficiary Satisfaction with Medicare HMOs and Fee-for-Service, 1996

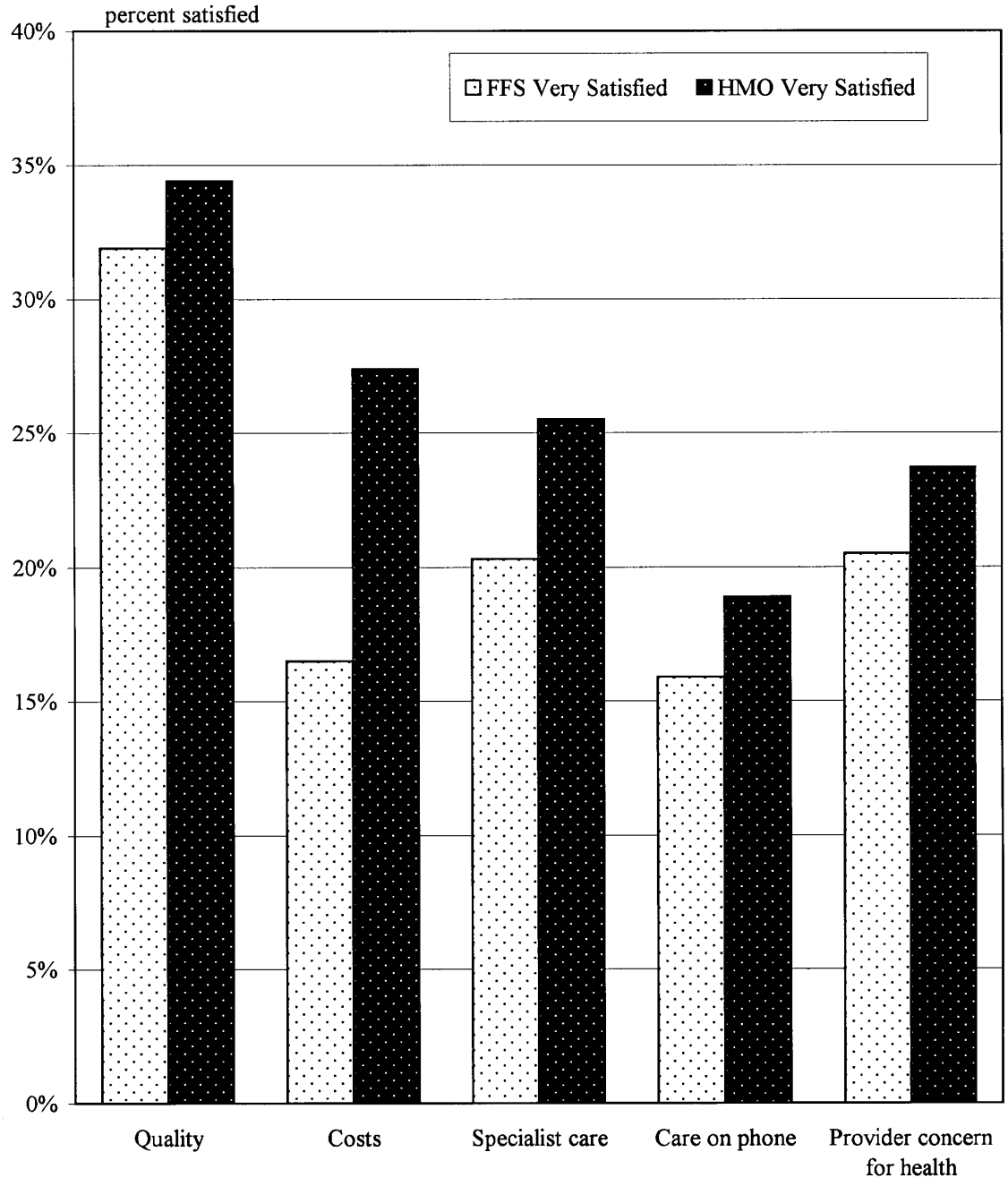
In 1996, Medicare beneficiaries enrolled in risk HMOs were more likely to report that they were very satisfied with the quality of and access to their care than those in Medicare FFS. While the differences in satisfaction rates were generally small, they are notable with respect to the issue of costs. Whereas 27% of risk HMO enrollees reported that they were very satisfied with the costs of their care, only 17% of beneficiaries in FFS were very satisfied.

TABLE 4.21. Beneficiary Satisfaction with Medicare HMOs and FFS, 1996

Type of Service	Percent Very Satisfied FFS	Percent Very Satisfied HMO
Quality	31.9	34.4
Costs	16.5	27.4
Specialist care	20.3	25.5
Care on phone	15.9	18.9
Provider concern for health	20.5	23.7

Note: Table prepared by CRS.

Figure 4.21. Beneficiary Satisfaction with Medicare HMOs and Fee-for-Service, 1996



Source: Figure prepared by CRS based on HCFA, Office of Strategic Planning, *A Profile of Medicare Chart Book*, 1998.

Figure 4.22.
Beneficiary Dissatisfaction with Medicare HMOs and Fee-for-Service, 1996

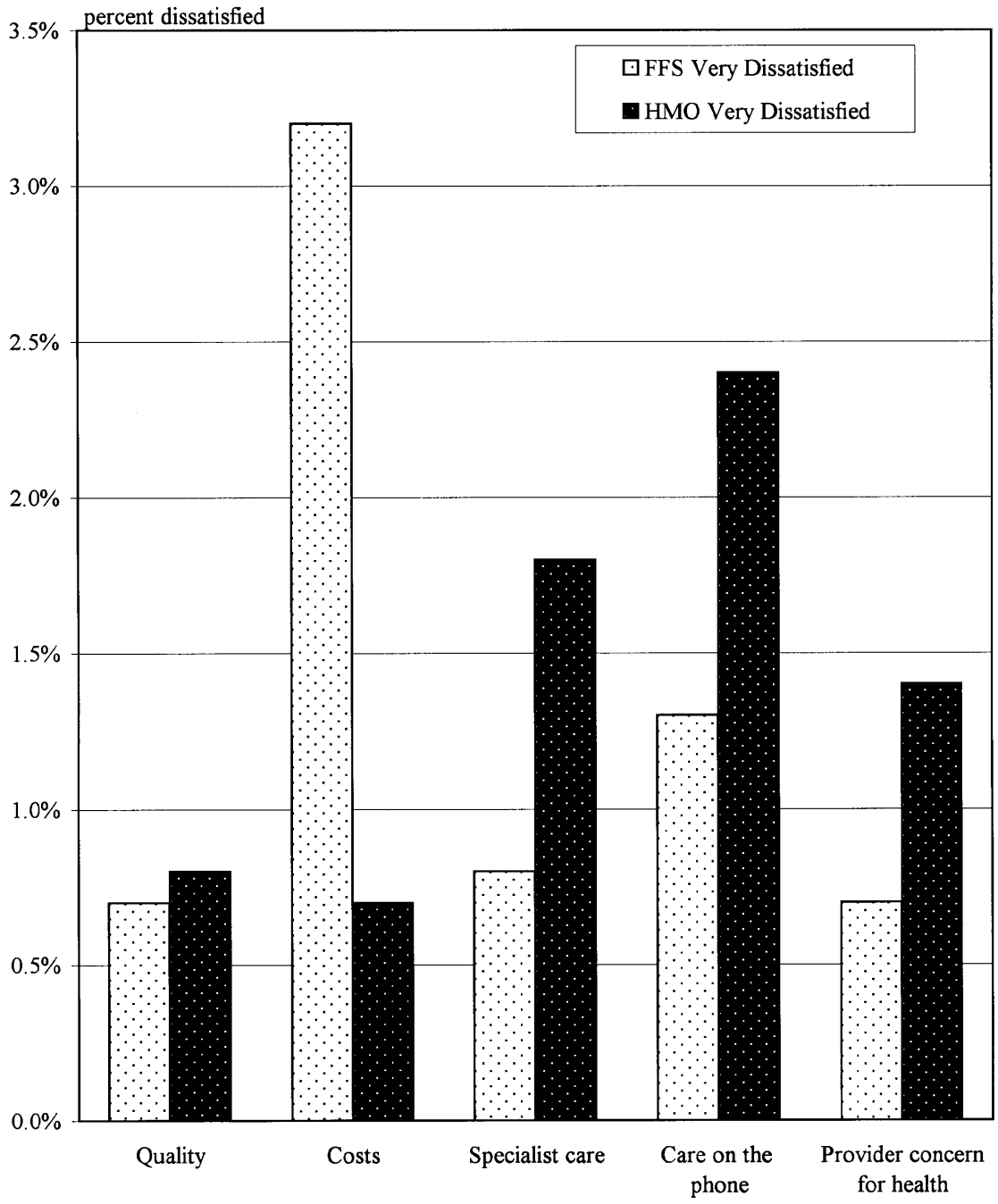
Only a small percentage of Medicare beneficiaries reported being very dissatisfied with their Medicare coverage in 1996. However, risk contract enrollees were likely to report being very dissatisfied about quality, and were twice as likely to report being very dissatisfied with specialist care, care on the phone, and their providers' concern for their health than beneficiaries with Medicare fee-for-service (FFS) coverage. The dissatisfaction rates are most notable for the differences on the issue of costs, where fee-for-service enrollees were more likely to be very dissatisfied than HMO enrollees.

TABLE 4.22. Beneficiary Dissatisfaction with Medicare HMOs and FFS, 1996

Type of Service	Percent Very Dissatisfied FFS	Percent Very Dissatisfied HMO
Quality	0.7	0.8
Costs	3.2	0.7
Specialist care	0.8	1.8
Care on the phone	1.3	2.4
Provider concern for health	0.7	1.4

Note: Table prepared by CRS.

Figure 4.22. Beneficiary Dissatisfaction with Medicare HMOs and Fee-for-Service, 1996



Source: Figure prepared by CRS based on HCFA, Office of Strategic Planning, *A Profile of Medicare Chart Book*, 1998.

Figure 4.23.
Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare Fee-for-Service, 1996

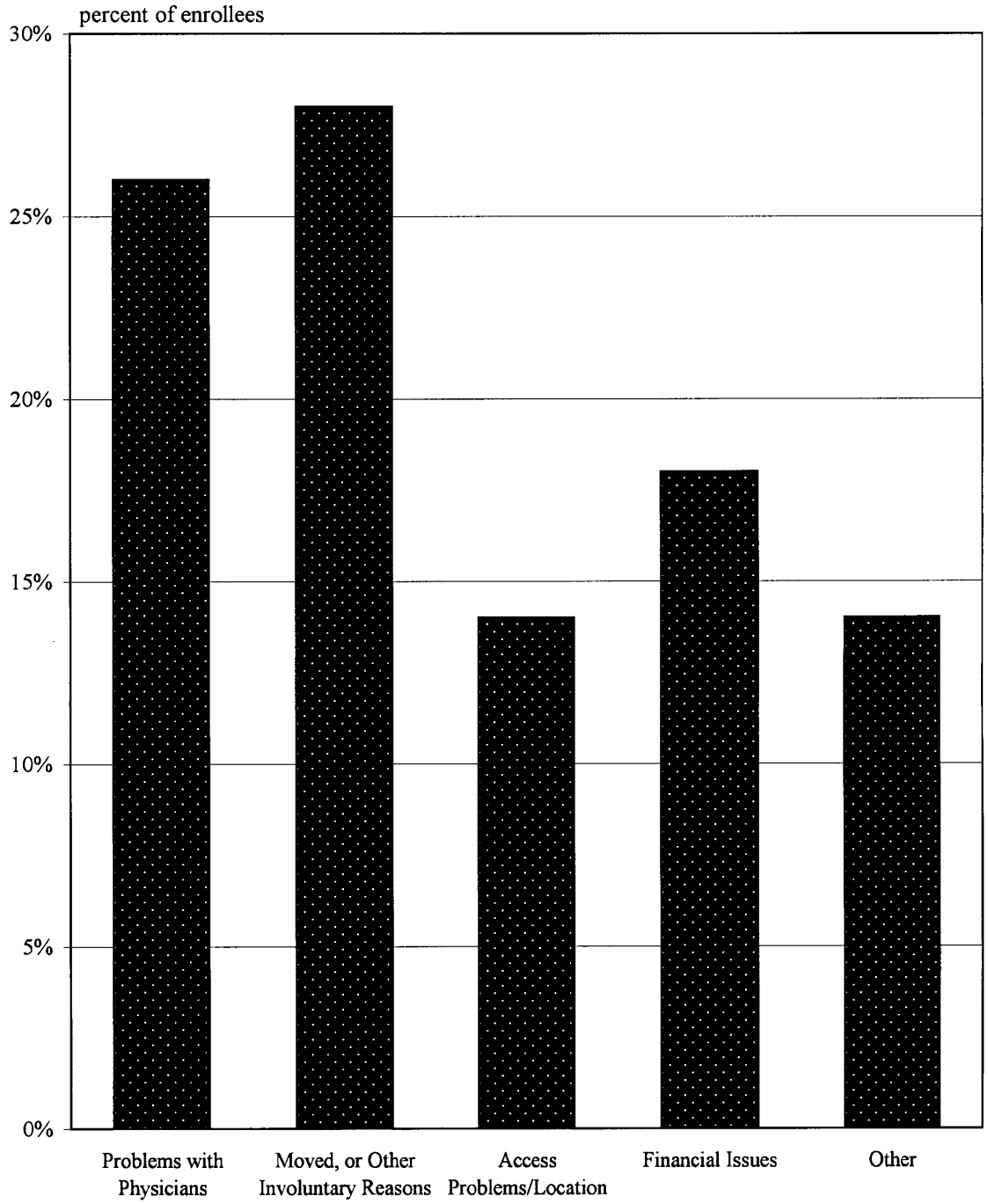
A telephone survey of Medicare beneficiaries enrolled in a risk HMO for at least 1 year during the year ending February 1996 revealed that those Medicare beneficiaries who disenrolled in favor of Medicare fee-for-service did so for a variety of reasons. Problems with physicians and access concerns motivated 40% of disenrollments to fee-for-service. More than 25% disenrolled because they moved or for other, involuntary reasons. Not shown in the figure is that beneficiaries who disenrolled from one risk HMO and enrolled in another risk HMO were more likely than those who switched back to fee-for-service to have left because their doctor left, died, or retired, and were less likely to have left because of access problems.

TABLE 4.23. Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare FFS, 1996

	Percent of Enrollees
Problems with physicians	26
Moved, or other involuntary reasons	28
Access problems/location	14
Financial issues	18
Other	14

Note: Table prepared by CRS based on PPRC survey.

Figure 4.23. Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare Fee-for-Service, 1996



Source: PPRC: *How Do Medicare Beneficiaries Fare in HMOs? Preliminary Results from PPRC Access Survey*, Update No. 4, Oct. 1996.

Figure 4.24.
Trends in Relative Growth in HMO Enrollment: Medicare Versus Non-Medicare Markets, 1988–1999

The rate of increased enrollment in Medicare risk HMOs surpassed that for non-Medicare HMOs every year from 1990 to 1996. Beginning in 1997, the rapid growth in enrollment in Medicare risk HMOs abated, and enrollment actually declined in early 1999 as the Medicare+Choice program began operation.

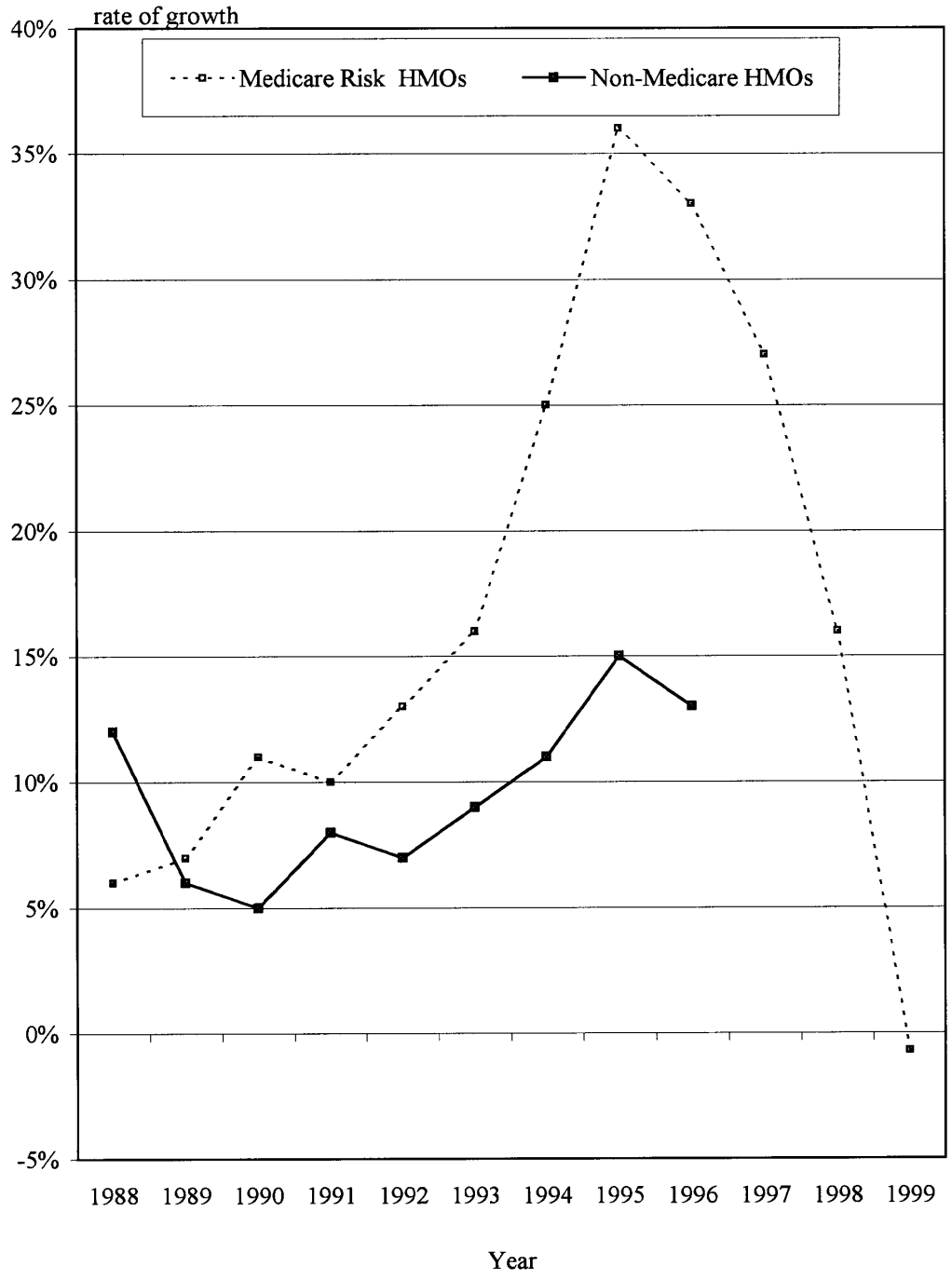
TABLE 4.24. Trends in Relative Growth in HMO Enrollment: Medicare Versus Non-Medicare Markets, 1988–1999

(in percent)

Year	Medicare Risk HMOs	Non-Medicare HMOs
1988	6	12
1989	7	6
1990	11	5
1991	10	8
1992	13	7
1993	16	9
1994	25	11
1995	36	15
1996	33	13
1997	27	—
1998	16	—
1999	−0.7	—

Note: Table prepared by CRS. Other forms of managed care delivery systems, such as preferred provider organizations, are not included in the non-Medicare HMO totals. 1999 data reports change between December 1998 and February 1999.

Figure 4.24. Trends in Relative Growth in HMO Enrollment: Medicare Versus Non-Medicare Markets, 1988-1999



Source: HCFA, *A Profile of Medicare Chart Book*, 1998, and HCFA, *Medicare Managed Care Contract Reports*, various years.

Figure 4.25.
Non-Medicare and Medicare HMO Penetration in Selected States, 1996

HMO penetration (the extent to which individuals enrolled in managed care plans) varied across states, for both Medicare and non-Medicare enrollment. In many areas, managed care companies have only recently begun to market to Medicare beneficiaries.

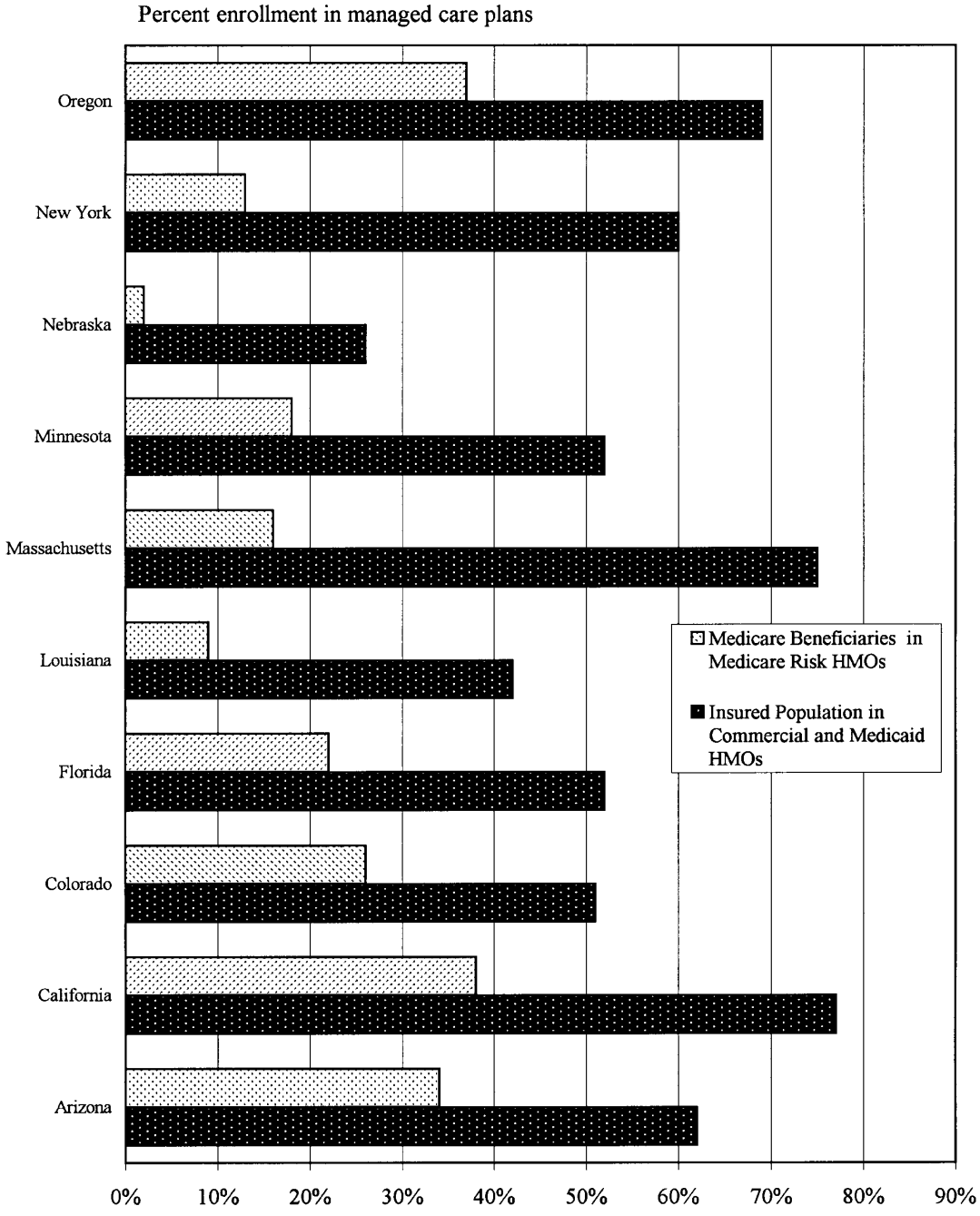
TABLE 4.25. Non-Medicare and Medicare HMO Penetration in Selected States, 1996

(in percent)

State	Insured Population in Commercial and Medicaid HMOs	Medicare Beneficiaries in Medicare Risk HMOs
Arizona	62	34
California	77	38
Colorado	51	26
Florida	52	22
Louisiana	42	9
Massachusetts	75	16
Minnesota	52	18
Nebraska	26	2
New York	60	13
Oregon	69	37

Note: Table prepared by CRS.

Figure 4.25. Non-Medicare and Medicare HMO Penetration in Selected States, 1996



Source: Figure prepared by CRS based on HCFA, Office of Strategic Planning, *A Profile of Medicare Chart Book*, 1998.

Figure 4.26.
Average Estimated Medical Education Payments as Components of Medicare+Choice Payment Rates, by Urban and Rural Location, 1998

Medicare fee-for-service payments for inpatient hospital stays include payments for indirect and direct medical education costs incurred by teaching hospitals and extra payments to hospitals that serve a disproportionate share of low-income beneficiaries (or DSH payments). The DSH payments are retained in the expenditures used to calculate Medicare+Choice payments to risk HMOs. Beginning in 1998, Medicare+Choice payments exclude medical education costs with a phase-out of 20% of costs in 1998, 40% in 1999, 60% in 2000, 80% in 2001, and 100% from 2002 onward. As a result, the Medicare+Choice payments reflect a county's average monthly per capita cost for fee-for-service DSH and part of medical education costs. These amounts may not correspond with actual plan costs, however, because not all Medicare+Choice plans have medical education programs or use teaching or disproportionate share hospitals. In 1995, medical education was an estimated 3.4% of the rates overall, and DSH was 2.1%. The share of medical education costs was 3.2% overall in 1998. This share varied across the country, as shown in the figure.

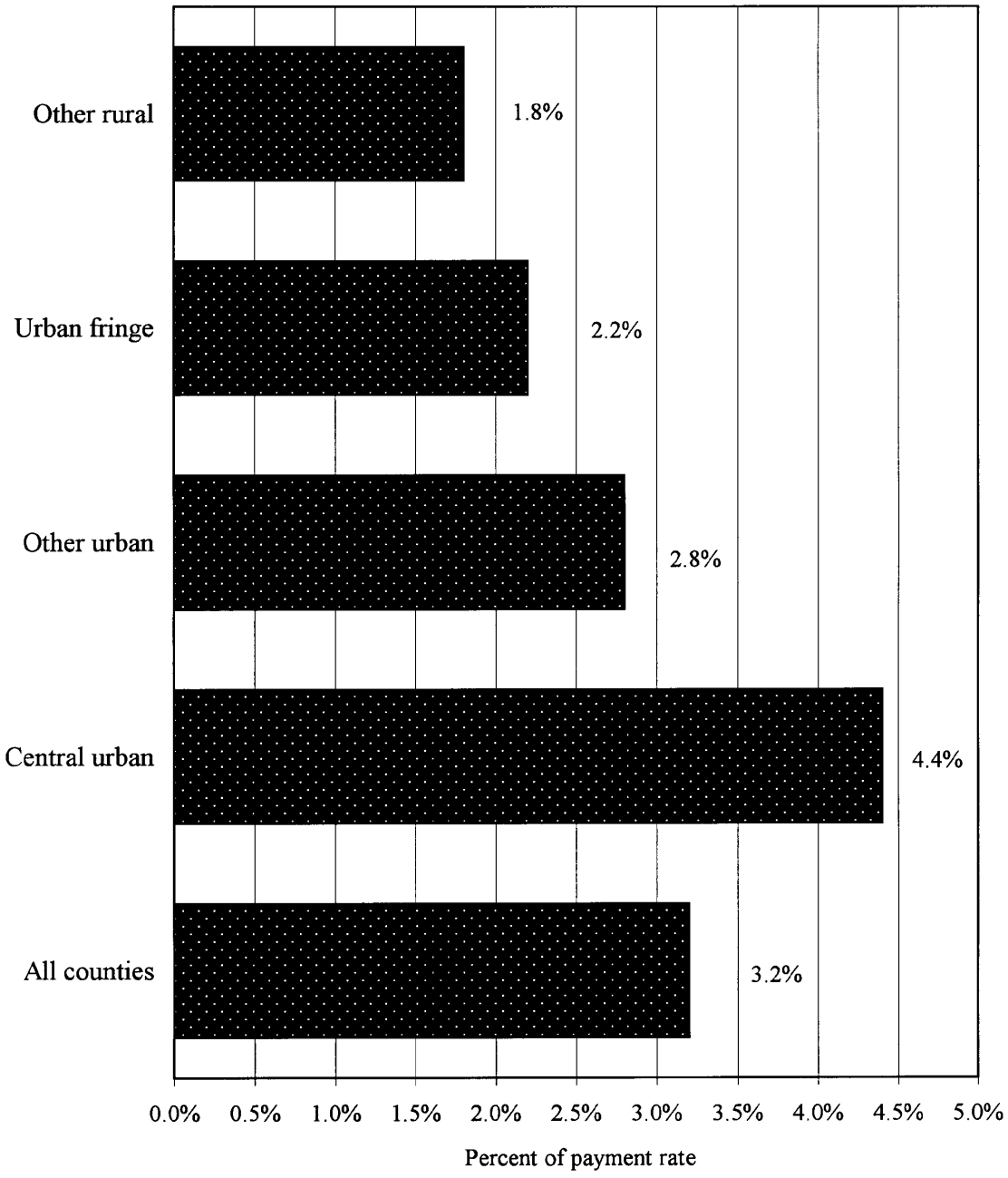
TABLE 4.26. Average Estimated Medical Education Payments as Components of Medicare+Choice Payment Rates, by Urban and Rural Location, 1998

(percent of payment rates)

	Medical Education
All counties	3.2
Urban counties	3.6
Central urban	4.4
Other urban	2.8
Rural counties	2.0
Urban fringe	2.2
Other rural	1.8

Note: Table prepared by CRS based on HCFA data. Average percent weighted by number of aged beneficiaries per county in 1996.

Figure 4.26. Average Estimated Medical Education Payments as Components of Medicare+Choice Payment Rates, by Urban and Rural Location, 1998



Source: Figure prepared by CRS based on HCFA data. Average percent weighted by number of aged beneficiaries per county in 1996.